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JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES

EDITED BY  
PRINCE A. MORROW, A.M., M.D.

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VOLUME VI.

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NEW YORK  
WILLIAM WOOD & COMPANY  
56 & 58 LAFAYETTE PLACE

1888

CONTRIBUTORS TO VOL. VI.

ALLEN, C. W.	KLOTZ, H. G.
BLANC, WM. H.	LEWIS, DANIEL.
BREWER, G. E.	McGUIRE, J. C.
BRONSON, E. B.	MORROW, P. A.
BROWN, F. T.	NEELEY, E. A.
BRYCE, C. A.	OHMANN-DUMESNIL, A. H.
CABOT, A. T.	PARK, R.
CULVER, E. M.	PIFFARD, H. G.
CUTLER, C. W. •	REYNOLDS, H. J.
ELLIOT, G. T.	SMITH, T. C.
FENWICK, E. H.	STEIN, A. W.
HEITZMANN, LOUIS.	TAYLOR, R. W.
KINNIER, D. F.	WHITE, J. B.



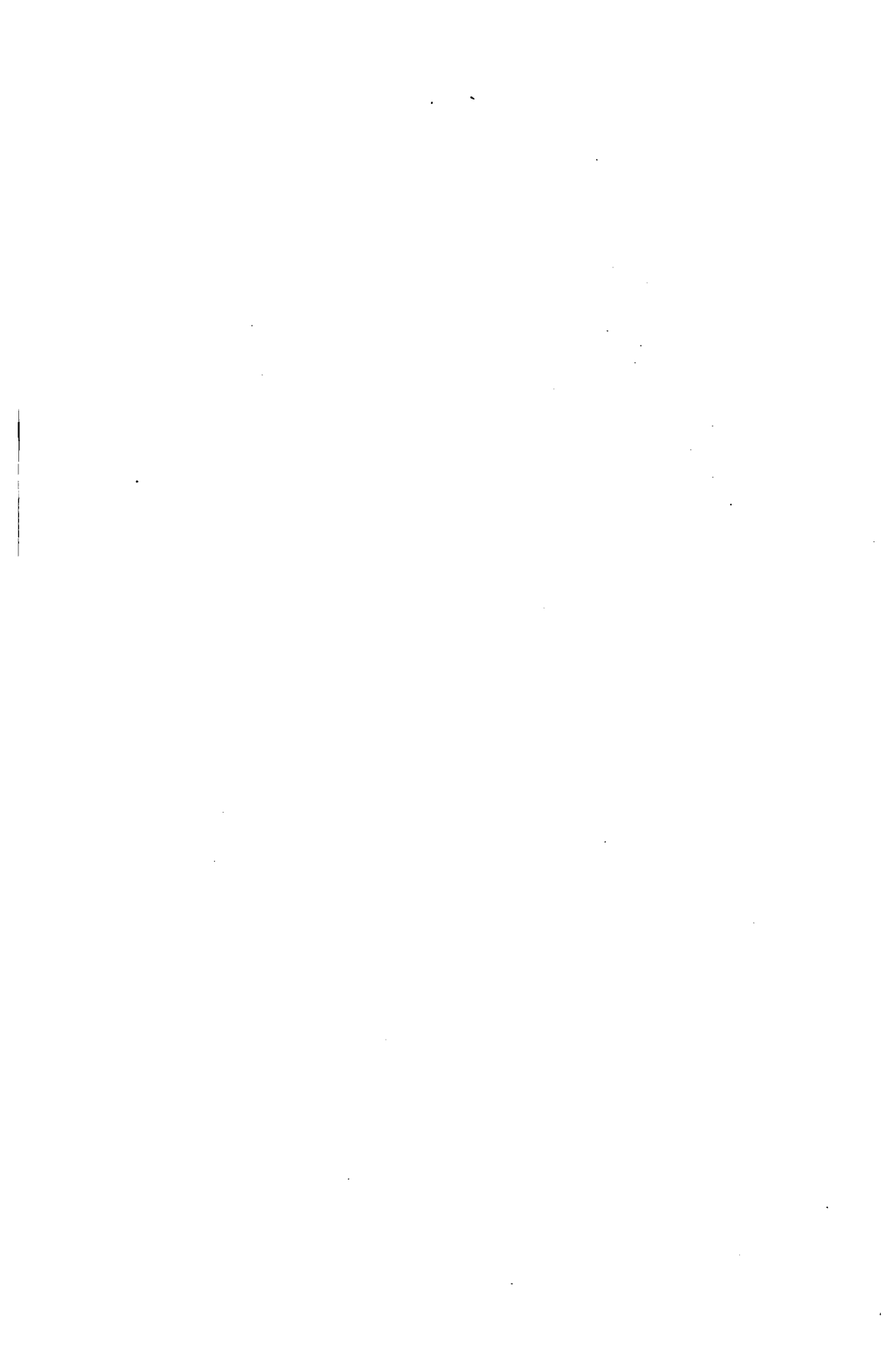




FIG. 1



FIG. 2

FIG. 3

FIG. 4

Figs. 1 and 2 Syphilitic Perionyelia.  
3 and 4 Bullous Syphilidè. (Hereditary).

JOURNAL  
OF  
CUTANEOUS  
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VOL. VI.

JANUARY, 1888.

No. 1.

**Original Communications.**

CLINICAL SYPHILOGRAPHY: No. 1. THE BULLOUS SYPHILIDE,  
(HEREDITARY): DIFFUSE ECTHIMATOUS PERIONACHIA.

BY

R. W. TAYLOR, M. D.

Surgeon to Charity Hospital.

SUCH is its exceeding rarity in the acquired disease, that the bullous eruption may almost be considered the sole appanage of hereditary syphilis. The bullous syphilide of the new born is in my experience rather rare. In the wards of Charity Hospital and in the Maternity Service, which is, perhaps, the largest in the world, I have for many years seen one or perhaps two cases each twelve months.

The clinical history of this eruption is very clearly marked. It is undoubtedly the most precocious of all the syphilides of hereditary origin, appearing either within a day or two or a week after birth, usually within and not commonly after the first month, and often being found on macerated and aborted children in the sixth or seventh month of gestation. Its development is as rapid as its appearance is precocious, and while in many cases it is confined to the palms and the soles, in others it is found usually less characteristically developed also upon the limbs, trunk and face. Upon the palms and soles it reaches its fullest development, and there we find various sized bullae, the



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contents of which often have in twenty-four hours changed from a sero-purulent to a purulent fluid. The lesions are seated upon an hyperæmic surface, often of a violaceous or purple tint, and again of deep coppery red hue. Elsewhere upon the body this tinted background is wanting, and there is usually to be seen a more or less extensive coppery red areola surrounding the lesions which in these localities, as a rule, are not of as well marked bullous character as are those on the hands and feet. The eruption as thus seen might often be called pustular. A peculiarity of the hereditary bullous syphilide which I have noted in a number of cases is that if successive crops appear, which, by the way, is of infrequent occurrence, they do so very promptly and with only short intervals between each. When the eruption appears, a month or later after birth, it is never in my experience as fully developed as when it shows itself at, or a few days after birth. While eruptions of the other hereditary syphilides often co-exist with each other, it is one of the greatest rarities to find any other than a well-marked pustular syphilide upon an infant suffering from the bullous eruption or perhaps an erythematous or papular eruption.

The bullous syphilide is the expression of a profound poisoning of the system, and is usually accompanied by visceral lesions, consequently its prognosis is almost always bad. Neumann says that he has only seen one instance of recovery, while I am happy to state that I have seen two. One of these cases occurred in the Charity Hospital Maternity Service of my friend Dr. H. J. Garrigues, and was by him placed under my observation. The facts concerning it are as follows:

The mother's history: She was twenty-eight years old, had been married three and a half years. She had never had syphilis, according to her story, and no history or evidence whatever could be obtained pointing to it. She had had two abortions at the seventh month, and three months previous to the first had lost her hair. She was delivered in the Maternity division of Charity Hospital, 10.35 P. M., February 24, 1887, of a male child. On the following day a vesiculo-papular eruption appeared on its buttocks and its scrotum became œdematous. In a few days this eruption became more general. On the soles of the feet and palms of the hands was a bullous eruption seated upon a coppery red erythematous surface. The cervical, epitrochlear and inguinal ganglia were markedly swollen. The characteristic little-old-man look of syphilitic children was well marked, and the snuffles and raucous voice were symptomatic. During the



succeeding days the bullæ became larger and their contents changed from sero-pus to pus. Several ruptured and left ulcerated excoriations. Under treatment all the lesions improved, and by March 12th were nearly healed, and in two weeks after that the child was free from eruption, excepting the coppery color and slight scaling of the palms and soles. It is noted that on April 12th the child nursed and slept well, its general condition was good, and there was no longer any perceptible swelling of the ganglia.

The evidences of syphilis presented by this child are as follows: the old-man appearance, pemphigus, erythema, laryngitis, snuffles and enlarged ganglia.

The treatment which acted so promptly and effectively consisted in the administration of the twentieth of a grain of proto-iodide of mercury combined in powder form with one grain of lactate of iron, three times daily.

The course of the bullæ in this case was in keeping with the general character of the disease underlying it. The picture shows numerous separately placed, not much elevated, flat bullæ, quite tense and containing a yellow pus. They averaged in size from the diameter of a line to that of a ten-cent silver coin. Having reached these sizes they began to wither, thereby, of course, not showing the tendency to coalesce which is so often seen in this syphilide. Notwithstanding that a few bullæ ruptured, the resulting ulcers were not, as is frequently seen, deep, destructive and rebellious to treatment, but rather superficial with no malignant tendency and responsive to medication. The majority of the lesions dried and withered, leaving a pigmented scaly surface which gradually became normal. As the bullous eruption underwent involution, the general condition of the child improved. It ceased to cry and fret, it lost its raucous voice and its snuffles, its appetite became good, its bowels healthy and regular, and its sleep was refreshing. The old-man appearance, with its thin, withered, drawn and unhealthy colored skin, gave way to plumpness and a comely appearance. Severe cases present a picture in marked contrast to the foregoing. The miserable woebegone appearance increases, the snuffles and the hoarse voice become more severe and present great hindrance to respiration. The ulcers become malignant, even gangrenous, the appetite is wanting, and a severe diarrhœa sets in. Thus ill-nourished and miserable, with all its severe local symptoms, it presents a pitiable spectacle and dies of marasmus, medicine being powerless to relieve. The almost universal acceptancy to-

day of the view that syphilis may be transmitted from a father to his offspring, while the mother remains free from that disease, renders it unnecessary for me to discuss the question here. When, in 1876, I, as the pioneer in America, published my paper, entitled<sup>1</sup> "A contribution to the study of the transmission of syphilis," and emphatically endorsed the view, supporting it with what I think is very strong clinical evidence, there were many who dissented from it. A further experience of eleven years has tended to increase my conviction, and it is pleasing to know that in all countries there are to-day only five authors of note who are opposed to this view. I constantly see in Charity Hospitals cases of syphilitic children, cared for by mothers who present no sign, symptom or history of syphilis. Many of these women remain for long periods and are watched carefully. Such cases usually awaken a keen interest in the minds of the internes, who follow them up with unusual zeal and assiduity. Such occurred in this case at the hands of my excellent house surgeons, Dr. Bosch and Dr. Gilley. The result, as stated, was absolutely negative as to the existence of syphilis past or present in the mother. I am strongly of the opinion that the denial by some of the older observers of the syphilitic origin of pemphigus in infants was based on the coincidence of children presenting this eruption and born of mothers who showed no sign and gave no history of that infection.

So strongly marked are the clinical features of the bullous eruption of hereditary syphilis that an error in diagnosis is not likely to be made. The simple form of pemphigus in children never begins primarily upon the palms and soles, but upon the neck, upper part of the trunk, and from there it may spread. The bullæ of simple pemphigus are larger, their contents more serous, becoming puriform slowly, and they are surrounded by a rose-tinted areola, and seated upon normal skin. They show little tendency to undergo ulceration unless irritated, and are never accompanied by the constant concomitants of the specific eruption. The two pictures are sharply and clearly marked, and error can scarcely be made if they are borne in mind.

#### DIFFUSE SYPHILITIC PERIONYCHIA.

M. M., female, married, aged thirty-eight, a blonde of poor fibre, is an inmate of Charity Hospital. The date of infection in her case is in doubt, but it was probably in October, 1886. In January and February, 1887, she had mucous patches in mouth

<sup>1</sup> Archives of Clinical Surgery, September, 1876.

and throat and a papular syphilide. In May of the next year she was attacked by precocious gummatas of the hands and legs. During all this time she was neglectful of herself, and took occasional indifferent courses of treatment. In June last the thumb and index finger of the right hand and the middle finger of the left became affected, and in July the little finger of the right hand and the index finger of the left were similarly attacked. In August her hair fell out profusely. In her occupation of dressmaker she used constantly the thumb and forefinger of the right hand and the little finger was constantly irritated by contact with the goods worked upon. Of the left hand, she used the index and middle fingers the most. It is interesting to note that all of the fingers subjected to constant use and motion these are the ones the seat of the syphilitic lesions. Continual use and friction, therefore, were beyond doubt the determining causes of the localization of the disease in these members. The chromo-lithograph shows the resulting perionychia in what may be termed its period of full development. The affection began as a slight hyperæmia in the skin of the distal phalanges of the already specified fingers. This hyperæmia was bright, diffuse, and not limited to the nail. Thus, for two or three weeks the case presented simply a reddened condition of the distal portion of the affected fingers. As there was no pain present, the woman continued at her work. In this very subacute manner the bright red deepened into a coppery hue and the affected parts became swollen and bullous, or of the shape of an Indian club, due to syphilitic inflammation and infiltration. Coincidentally with the intensification of the disease the nails became affected and were destroyed, seemingly struck by a blight.

This rapid necrosis is peculiar to this form of perionychia. The nail first loses its color, which becomes dull and dark, then its attachment at each border gives way first, and after that in its whole extent, ulceration with the formation of a thick ill-smelling pus taking place beneath it. The nail then rapidly becomes considerably swollen, uneven and puckered and of a black and green color well shown in the plate. With the onset of the nail affection pain becomes an important element in the case and the fingers are then useless for any function. The imbedded portion of these appendages is the one which gives the most trouble. Here the destructive process is usually not sufficiently great to cause the spontaneous extrusion of the nail, and this sequestrum remains, causing severe pain, acting as a foreign body and keep-

ing up the ulcerative process. Frequently in these cases so severe is the inflammation that the fore arm and arm become red, swollen and painful, with sympathetic implication of the axillary glands, attended by high fever, malaise and much suffering. This lymphangitis was observed in the present case. When, however, the dead nail is removed and appropriate treatment is adopted, the coppery red phalanx loses its tension, becomes superficially wrinkled and of a purplish red color. The ulcerated surface left by the fall of the nail becomes less anfractuous and healthy granulations spring up. Then from the basal sulcus in a few months, usually about two, the encroaching end of a new nail shows itself, and it progresses in a more or less perfect manner until finally the whole nail matrix is covered. Frequently the new nail at first is wrinkled and far less comely than its predecessor, but under favorable circumstances it gradually becomes normal. In severe and uncared for cases, the matrix of the nail is entirely destroyed, and then no new nail is formed. This result is often seen when the intensity of the ulceration is spent at the basal portion of the lunula.

The treatment of this affection is both internal and local and it should always be promptly begun and intelligently carried out. In the present case, such was the severity of the pain and swelling that for a day or two lead and opium wash was used. The stumps of the nails were extracted at the earliest moment, since this I regard as an essential part of local treatment. Much relief was obtained from frequent and prolonged immersion of the hands in very hot water to which a small quantity of borax was added. Besides its soothing effects it cleared the parts of the offensive pus which so constantly and profusely forms. Then the morbid surfaces were lightly dusted with iodoform and the whole of the phalanges were enveloped in linen smeared with an ointment composed of half an ounce each of Ung. Zinci oxidi and Ung. Hydrarg. fort., or the white and the blue ointment, as it is called in the hospital, combined with one drachm of the aqueous extract of opium. An important adjunct to treatment in this stage is pressure by means of a bandage, which should be as firm as can be borne and continuous. Besides lessening the congestion, it tends to produce a more symmetrical finger.

In contrast with this, the diffuse form of syphilitic perionychia, there is that ulcerative form which begins at some spot along the sulcus at the attached margin of the nail, as a papule pustule or fissure and then destroys more or less of the nail, the

destruction being greatest in those cases in which the morbid process begins at the basal portion of the sulcus. These and other forms of syphilitic nail disease I have described in my treatise on Venereal Diseases (Bumstead and Taylor, page 630 to 634).

The severity of the syphilis in this case and the precocious appearance of gummatous lesions are points of interest and prove beyond a doubt that the lesions in the fingers were due to this peculiar cell change, supplemented by active hyperæmia.

40 West 21st Street, New York.

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TWO CASES OF  
PROSTATOTOMY FOR OBSTRUCTION.

BY

A. T. CABOT, A. M., M. D.,  
Boston.

SINCE the time of John Hunter, operations upon the prostate, for the relief of obstruction, have occupied more or less of surgical attention.

At first these were undertaken only in very severe cases and the prostate was reached by perineal incisions either central or lateral.

In 1830 Mr. Guthrie by internal incision with a urethrotome divided a "bar at the neck of the bladder."

In France, in 1832, M. Leroy d'Etiolles advocated the scarification of obstructing bands or prominences at the neck of the bladder, and in 1838, Mercier devised instruments for the more thorough internal incision of the prostate, and for the removal of portions of the obstruction in severe cases.

This operation, according to Mercier, was followed by very good results in the relief from difficulty of micturition, but it had the disadvantage, that it sometimes caused troublesome hemorrhage, which it was hard to stop even with cold and astringent injections.

Among other operators this method has met with varying fortunes, and though supported by some strong advocates, it has never come into good repute with the majority of surgeons. Dangerous hemorrhages after it have been reported.

It is of the perineal operation, now again revived, that I wish, however, especially to speak.

In the past fifty years the bladder has been opened occasionally through the prostate for purposes of drainage, but the perineal operation for the relief of obstruction, though some-

times put in practice, was much neglected until it was again brought into prominent notice by Mr. Reginald Harrison, who read a paper on this subject before the International Medical Congress at Copenhagen, in 1884.

His operation was essentially one which had been practiced before, and consisted in a median incision into the membranous urethra, the passage of the finger through this into the prostate and on this finger as a guide the section of the obstructing portion, whether a bar or a projecting third lobe.

It was in the after-treatment, however, that Mr. Harrison's method differed from those previously in use, and his result seemed to show that the changes which he made were of importance. These changes consisted in the employment of measures for moulding the prostatic canal during healing.

At the time of operation he introduces a large, stiff-walled gum-elastic tube through the perineal wound into the bladder. This he leaves in place for from six to eight or even twelve weeks, and after removing it he keeps the patient for a long time upon the almost daily use of a large bougie to preserve the patency of the canal made by the tube.

In his report to the International Congress at Copenhagen upon this method of procedure, he cited one case in which the result was excellent, with great relief to the difficulty of urination, and said this was but a sample of many.

Such is a brief outline of the more important and serious efforts for the relief of prostatic obstruction by operation.

There have been scattered along through surgical literature, isolated reports of cases in which operations done for bladder drainage or for the removal of stone by incision through the prostate have been followed incidentally by considerable relief of previously existing obstruction, but these had not, until Harrison interested himself in the matter, led to the systematic study of the subject, nor to the establishment of a definite operative procedure and appropriate after-treatment.

His method is now on trial, and it is important to establish its range of usefulness by the accumulation of facts favorable and unfavorable. The cases which I have to report are contributed to swell the statistics. They illustrate very well the relief from obstruction which can be gained by this operation, and also furnish an example of what may prove to be one of its disadvantages.

CASE I.—T. C——, a carpenter, sixty years of age, a patient of Dr. Walker of Edgartown, came into my wards in the Massa-



chusetts General Hospital through the advice of Dr. R. M. Hodges.

He had suffered for several years from almost complete prostatic obstruction with consequent cystitis. For the last few months before I saw him he had had an increase of pain referred to the bladder and to the end of the penis, and greatly aggravated when he drew his water, which he was obliged to do rather oftener than once an hour, as he suffered greatly from vesical tenesmus if he tried to go a longer time. The catheter that he used was a small one, No. 14 French scale, and this he had come to on account of the pain in the deep urethra caused by larger instruments.

When he first reached Boston, the prostate was large, hard, hot and tender. A week in bed, with treatment by anodynes and hot fomentations, greatly reduced the inflamed condition of this gland.

He was now etherized and sounded, with the result of finding a stone. The lithotrite was introduced for the purpose of measuring it to see if it would come out through a median incision; but the stone became so engaged in the jaws of the instrument that it could not be freed, and it was therefore crushed and pumped out. It was soft, phosphatic, and weighed but eighty-five grains, so that this procedure occupied only a few minutes.

The patient was then put in the lithotomy position, the membranous urethra was opened on a grooved sound and through the opening the finger was passed into the prostate.

The middle lobe was found to be very prominent, though not pedunculated. It was split through the middle with a probe-pointed bistoury and the entrance to the bladder was then felt to be perfectly free. A large rubber tube was introduced and fastened in the bladder.

This operation was followed by very little reaction, and recovery went along smoothly until the fourteenth day, when there was a sudden rise of temperature and a swelling of the epididymis. This inflammation went on to suppuration and was finally laid open under ether. At the same time the bladder was again thoroughly washed out with the evacuator and a last small fragment of stone was obtained.

After this time everything went well. The tube was removed four weeks from the time it was put in, and the perineal opening rapidly contracted. The greater part of the urine was now passed by the urethra without any great effort.

He went home six weeks after the operation, and was then passing water naturally and easily.

He was seen again four months later, had gained between twenty and thirty pounds in weight and was looking well. There was still a pin-hole opening in the perineum through which a drop or two of urine occasionally escaped.

Urination was easy and the amount of residual urine was small, often but a few drachms. Frequency of micturition was variable; the intervals sometimes being several hours, and again not more than an hour.

Case II.—J. B—, farmer, aged sixty-two, was seen in October, 1886.

He had suffered from cystitis for five years. One year and a half before, I had seen him with Dr. Benjamin Cushing of Dorchester, who had found a stone in his bladder, which I crushed and removed. It was a soft phosphatic calculus weighing ninety-four grains.

This operation had been followed by a considerable relief of pain, but still the cystitis continued in spite of a pretty regular irrigation of the bladder. Urination was performed with difficulty, but the bladder very nearly emptied itself.

The difficulty of micturition slowly increased until the obstruction was so great that in order to pass water he was obliged to squat down close to the floor, and then with great effort he could only squeeze out an ounce or two at a time. The urine was strongly ammoniacal with much thick pus in it. He was again carefully examined for stone, but none was found.

In the hope of relief from the extreme difficulty of micturition, he agreed to an operation, which was done October 26, 1886, in the same manner as in the last case.

The prostatic urethra was not very long or very tight, and the obstruction was found in the shape of a narrow bar at the entrance to the bladder. Whether this was in the prostate or on the vesical floor just posterior to it, could not be accurately made out.

It was incised with a probe-pointed knife, and after the bladder had been explored as far as possible for a tumor or sacculated stone, with negative results, a large rubber drainage tube was introduced through the prostate, and secured in place.

The drainage brought him great relief from pain, and the urine improved much in character. The tube was removed at the end of a fortnight, and the opening in the perineum quickly contracted.

The patient could now urinate freely in a standing posture with a considerable stream. He went home much pleased with the improvement in his condition. Directions were given him to continue the daily irrigation of the bladder with the frequent use of a large sound.

Six months later I looked this patient up, and found that while the urination had remained easy, he had, through neglect of irrigation, allowed the cystitis to return, and, in consequence, suffered from some discomfort in the region of the bladder. Six weeks before I saw him at this time, he had begun to suffer from incontinence both by night and day.

This was not an overflow, as the bladder very nearly emptied itself in urination, and yet the leakage appeared soon after passing water.

It seemed then to be true incontinence from lack of muscular power at the neck of the bladder, probably aggravated by the inflamed condition of the bladder.

The perineal opening still allowed the occasional escape of a drop or two of water.

This patient was again heard from a year after operation. He had been attending more faithfully to the irrigation and his bladder was consequently in better condition. The frequency of urination was not great, and the incontinence had disappeared.

In the first of these cases, we had a condition favorable for operation, and in which the result was decidedly satisfactory. The second case is more interesting, as it presents a less encouraging result, and illustrates a condition, which may follow the operation, against which we should, I think, be warned.

In seeking a cause for the incontinence in this case, certain things suggest themselves, which may be worth consideration.

The incision through the obstruction was not a deep one, and the tube was left in for but a fortnight instead of for six or seven weeks, as Harrison advises. We cannot, therefore, hold either the extent of the division of the neck of the bladder nor a too long distension of the parts with the tube, responsible for the subsequent incontinence. It is to be remembered, however, that in this operation, the incision through the membranous urethra necessarily divides the cut-off muscle, and in some instances, no doubt, after healing interferes more or less with its sphincter action.

When this occurs in a patient whose bladder is weakened by long distension, it is not likely to cause incontinence, or can give rise to it only when the bladder is much distended. On the other hand, in a patient like ours, with a vigorous bladder, incontinence may be a more frequent result, especially when cystitis exists and the bladder wall is constantly excited to spasmodic contractions.

It is manifestly impossible to draw any conclusions from one case, but subsequent experience may show that it is better surgery in cases like this, with evidence of a powerful, probably hypertrophied bladder, to do an internal prostatotomy and so avoid interference with the constrictor muscle.

It is just in such cases, when the bladder has the power to expel its contents and the obstructing bar is a narrow one, that the internal operation is applicable, if ever.

The perineal operation, with its dependent drainage, is vastly superior for the more common cases in which atony and distension of the bladder behind the obstruction have occurred; for in these the long rest of the bladder in a contracted state gives it time and opportunity to recover its power.

The advantage of external prostatotomy in enabling the surgeon to make the section of the gland with precision, is too evident to need argument. With the forefinger as a guide, obstructing portions may be incised or cut away, and through the perineal wound the after dilatation of the parts, during healing, is much more easily managed than is possible through the urethra.

The superiority of this operation must, however, not cause us to close our eyes to its occasional shortcomings, and we may find that by careful study of our cases we shall sometimes be led to prefer the internal incision.

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DERMATOLOGICAL NOTES—ERYSIPELOID—HERPES TONSURANS  
MACULOSUS—URTICARIA PIGMENTOSA—ACUTE CIRCUM-  
SCRIBED OEDEMA—TREATMENT OF EPITHELIOMA  
WITH LACTIC ACID.

BY

GEORGE T. ELLIOT, M. D.

Attendant Dermatologist Dermitt Dispensary, Assistant Physician New York Skin and Cancer Hospital. Member New York Dermatological Society, etc.

ERYSIPELOID.

**K** S. —, female, age thirty, presented herself to me for treatment on September 17, 1887. She is a perfectly healthy woman, who attends to all the cooking, washing and other duties of her household. She states that she has already suffered from the affection and that it has always shown itself on the palms alone. The disease appeared in August, 1885, for the first time. It was then situated on both palms and lasted about four weeks. The second attack occurred in October, 1886, and was limited to the left palm. The present outbreak is also upon this same surface, but in addition has developed on the ball of the foot and the dorsal surface of the toes.

The affection appeared on September 10th, as a small red spot near the centre of the palms. This lesion grew larger slowly, the portion of the skin first affected returning to its normal condition. This involution continued progressively with the advance of the disease, which, when I saw her, had marched over almost the entire palm, and was found to consist of a zone

of violaceous redness, about one-third of an inch broad, only slightly elevated, but sharply defined in regard to the unimplicated skin. It began at the root of the middle finger and extended in a more or less curved manner to the upper border of the palm and along this to the ulnar side of the hand, where it ceased abruptly. The space enclosed by this zone was entirely normal, but yet it had been the seat of the process. Similar appearances were observed upon the palmer surface of the first phalanx of the middle finger. The lesion there had pursued the same course as the one on the palm had, but it had only been present four days, and consequently was not so extensive. On the feet, the process had also begun later than on the palm and was represented by a half circle on the ball of the left foot, while on the right foot, the dorsum of the great toe and of the first and second toes were the portions affected. The symptoms here were the same as those which were seen on the palm.

Throughout the course of the disease there had been no desquamation, no papules, vesicles or other lesions present, nor did any such objective symptoms develop later. Subjectively, the patient stated that there was severe itching and burning in those portions affected, but there had been and there was no participation of the general system, no fever, etc. I prescribed for her a fifteen per cent. ointment of ammonium-sulfoichthyol, and on September 22d the disease had entirely disappeared.

She returned, however, on October 6th, with a relapse, which had begun two days before. Two incomplete circles, about size of a nickel, were observed on the left palm, and the toes of the right foot were also affected. The development of the lesions and the objective and subjective symptoms presented by them were exactly the same as were present during the previous attack. The use of the ichthyol ointment was again instituted and in a few days the affection was cured.

Erysipeloid is not found described in any of the text books on Dermatology which I have been able to consult, but yet it is of interest, owing to the ease with which it may be confounded with some other diseases, and also to the fact that Rosenbach,<sup>1</sup> by cultivation and inoculation of a microbe found in connection with it, has established its mycotic nature. Rosenbach describes Erysipeloid as being a form of wound infection, which is communicated by the inoculation of the ectogenous germ which exists in all kinds of dead and decomposing material obtained from animals. It is consequently found especially among those who have to do with game, fish, etc., and for the same reason occurs most usually on the hands. The affection has no definite duration, but may disappear spontaneously in from one to three or four weeks.

Erysipeloid being a mycosis, its treatment is indicated. Probably any antiseptic application would be serviceable, still I would recommend an ichthyol ointment. It may be made with ungt. diachyli (Hebra) and the strength of the ichthyol should be from fifteen to twenty-five per cent. Its action in this case was immediate and so beneficial that it could scarcely be surpassed.

The affections from which erysipeloid is to be differentiated more especially, are erysipelas, ringworm and erythema annulare.

From erysipelas, the affection in question differs in being purely a local process, the general system being in no way affected. Besides, in erysipelas, the skin is swollen, shiny and considerably infiltrated, of a bright red color and the extension of the process is rapid. It does not proceed from the point of inception under the form of a comparatively narrow zone of redness as erysipeloid does, involution is not so progressive, and where it takes place a squamous surface results. Even erysipelas migrans, which in its course resembles more nearly erysipeloid, cannot come under consideration, since it is always accompanied by fever, emaciation and debility, often giving cause for the gravest fears. Ringworm also, beginning as a small red spot, ought to be readily recognized by its slow course, the scaly centre enclosed by the red elevated ring, the presence of the small vesicles or crusts upon this border, and more especially by the mycelia and conidii of the trycophyton tonsurans seen in the squamæ, when they are examined under the microscope.

The lesions more nearly resembling those of erysipeloid objectively are those characterizing that form of erythema multiforme, the erythema annulare. But yet this always appears symmetrically, follows the characteristic localization of the affection, becomes rapidly disseminated, is unaccompanied by itching, and is more or less mixed with other erythematous lesions, as papules, etc.

#### HERPES TONSURANS MACULOSUS, OR THE MACULAR FORM OF RINGWORM.

CASE I.—J. S—, age twenty-nine, presented himself to me February 27, 1885, and gave the following history: About one month ago, an eruption consisting of small red itchy spots had appeared upon the arms and upper portion of the body. By successive and repeated outbreaks, these had invaded the abdomen, back, thighs, in fact, the entire body except the scalp.



These erythematous spots had enlarged rapidly, involution taking place in the centre, which became covered with small squamæ. The itching was quite severe.

On examining the patient, it was seen that on the surface mentioned there were a multitude of lesions varying in size from a small pea to a fifty-cent piece. They were for the most part circular, but where the edges of two or more had come together in their peripheral growth, the portions in contact had disappeared, leaving a more or less irregular shaped lesion. The edges of the smaller spots were diffuse, not sharply limited, very slightly elevated and of a light brownish tinge, but the larger and older lesions approached nearer to the type of the ordinary ringworm. In the central portions of all, except those which had just appeared, squamæ were present, and on the red margin of some of the larger lesions there were a few small crusts. In the scales of the larger rings the trycophyton tonsurans was found with ease, but only a few spores could be discovered in those removed from the younger lesions.

CASE II.—N. V—, female, age twenty, came under treatment May 24, 1886. The eruption had appeared ten days before, shortly after having bathed and slept with another girl. She could not state, however, that the latter had any affection of the skin at the time. The lesions had shown themselves first on the chest and back and, by the simultaneous and continuous cropping out of new spots, had become widely disseminated over trunk and extremities. On examination, the lesions were seen thickly distributed over the surfaces mentioned and likewise a dozen or more had developed on the face. They varied in size from a pea to a twenty-five cent piece and presented the same general characteristics and appearance as were seen in the preceding case. The treatment prescribed was *R* Acidi Salicylici 3 i, Ungt Diachyli 3 i, and on June 10th the disease had disappeared entirely.

The macular form of ringworm is comparatively seldom met with, and differs from the ordinary form of the disease in the acuteness of its development and the extent of surface implicated. It may affect only a portion of the body, or be universal from the first. It is characterized by the simultaneous outbreak of an innumerable number of lesions as large as a pin-head, which rapidly enlarge peripherally, the formation of squamæ occurring in the central portions. In proportion as the lesions grow larger, they approach nearer to the type of the disease, the ordinary *tinea circinata*, and, for this reason, and also owing to the other objective symptoms presented by them, there is no special difficulty in making the diagnosis.

It ought not to be confounded with the annular form of

psoriasis, since in this latter the evolution of the lesions is much slower, the squamæ occur only on the erythematous elevated ring and not in the enclosed space, besides the localization more especially about the knees and elbows, and the punctate hemorrhage obtained by scratching the surface of one of the small new lesions will easily prevent any confusion being made between the two diseases.

The presence of the squamæ and the peripheral enlargement of the lesions will also be sufficient to distinguish the macular form of ringworm from the macular syphilide—the roseola syph. annularis.

In the treatment of herpes tonsurans maculosus, it is most important to apply the remedies not to the lesions alone, but over the entire surface of the skin on which they are situated. New outbreaks are continually occurring and new spots appear from day to day, so that even those portions of the skin apparently normal should be treated. In regard to the remedies advisable for these cases, not much is to be said. Any good parasiticide will be found serviceable when rightly applied. Sulphur ointment, fifty per cent. naphthalin ointment, or beta naphthol five to ten per cent., with or without *sapo viridis*, will all give good results. I prefer, however, salicylic acid in the strength of 3 i, to 3 iss ad 3 i. I use it either incorporated in ungt. diachylon or in alcoholic solution. I have obtained the best results with acid salicylici 3 iii, spts saponis kalinus 3 i. spts, vini rect. 3 ii. This solution should be rubbed in two or three times daily, by means of a piece of flannel or any other woolen stuff. In a few days extensive exfoliation of the epidermis takes place, the lesions fade out and the skin at the end of a week or ten days is again normal. Relapses may, however, occur, and they should be treated again in the same manner.

#### URTICARIA PIGMENTOSA.

Case 1—J. H.——, male, age ten months, was first seen by me in March, 1887.

The mother states, that just previous to becoming pregnant with this baby she had had a seven months' miscarriage and that she has always been delicate. Is again at present time pregnant. Her husband is and has always been perfectly healthy.

The little patient has also always enjoyed good health, has been nursed by its mother, and when the eruption first occurred was in every way perfectly well. The affection made its appearance at the age of three months and resembled ordinary urticaria. It began on the legs, but soon became universal. The

pigmentation developed shortly after the first outbreak. Mother states that the lesions are more apparent and prominent after a bath, or when the baby is excited or cries. At first, it did not seem to itch very much, but lately he is continually scratching. On examination, I found a large number of pigmented spots on the face. They were irregular in shape, not elevated, discrete in places, in others more or coalesced together and they varied in size from a pea to a penny. Their borders were not sharply limited, but faded gradually and their color varied between a reddish brown and a dark brown. The lesions were especially numerous on the buttocks and thighs; they were here as large as a bean, consisting of elevated papules, which did not desquamate and which were of dark brown and brownish red color. The slightest irritation increased the amount of spots, many of which, only visible on account of the pigmentation, became prominent papules.

The same characteristics were present on the legs, arms and trunk, but they were more thickly distributed over the back. On all of these surfaces there were a large number of dark brown spots, which had remained after the urticarial lesion had disappeared. Similar appearances were found on the scalp.

The baby was very costive.

Case 2—W. G.—, age three, male, was seen by me July 16, 1886. The mother and father are perfectly well and have always been so. The baby appears healthy, his appetite is good, but he is always costive. His diet is poor and he eats a great deal of salt meat.

The mother could not say when the eruption had first appeared, except that the lesions came upon the head and face while he was still a baby. On examination, I found the affection quite generally distributed, but the lesions were more numerous on the buttocks and thighs. On the legs, there were a number of fresh wheals about the size of a large pea, in the centres of which a small vesicle had developed. Here and there lesions were found in all stages of the process, from brown pigmented spots, with a still discernible papule in the centre, to dark chocolate-colored smooth surfaces. They varied in size from a nickel to a twenty-five cent piece and were circular or oval.

The pigmentation begins to appear as the wheals undergo involution, and, after being present for some weeks, gradually fades and disappears. New lesions and fresh pigmentation keep continually recurring. The eruption is very itchy.

This form of urticaria, a rare one, is not difficult of recognition. It always begins in early life, and the lesions at first are identical with the ordinary urticarial wheal. It persists for years uninfluenced by treatment, the pigmented spots remaining or

perhaps fading slightly, while some disappear altogether. It is accompanied by more or less severe itching and new lesions may be brought out by irritating the skin. It is only when the eruption is in the active stage, when a large number of brownish red, pigmented, elevated lesions are present, as in the first case mentioned here, that urticaria pigmentosa could be confounded with any other disease.

A papular syphilide is, perhaps, however, the only eruption for which urticaria pigmentosa might be mistaken. At the time the baby, J. H., was first seen by me at Demilt Dispensary, it was also seen by four or five others, who all diagnosed syphilis papulosa, yet if a little care had been taken in examining the objective lesions and also the general features presented by the entire process, such a diagnosis would easily have been avoided.

For a baby with papular syphilis will always present more or less evidence of the hereditary disease—want of development, malnutrition, cachexia—and a history of previous eruptions, or of lesions at time of birth or just after, is usually obtainable. The lesions are, according to their situation, of varying shades of red, from a light to a dark brown-red, their edges are sharply limited, not diffuse, and they offer to the touch a dense infiltration which is not removable by pressure. Mucous patches are invariably present ad anum, at the corners of the mouth, etc. Desquamation occurs after they have been present a few weeks, itching does not exist, nor can lesions be brought out by irritation; when they disappear, pigmentation does not develop and persist.

It can thus be seen that only carelessness could cause an urticaria pigmentosa to be taken for a papular syphilide, or vice versa, and the same can be said for other eruptions. Lichen ruber planus it is not necessary to mention, inasmuch as its occurrence in babyhood is of the greatest rarity, while eczema papulatum chronicum presenting, in addition to the small bright red papules, patches of infiltrated thickened skin with points of weeping, crusts, etc., and absence of pigmentation, is so easily recognized, that it could never be mistaken for urticaria pigmentosa. The treatment of this form of urticaria is entirely unsatisfactory. None of the remedies, which benefit the ordinary manifestations of the disease seem to influence it. About the only thing to do is to protect the child from all cutaneous irritation and to see that all of its functions are kept in proper healthy condition. After the affection has subsided and only the pigmentation remains, means could be taken to

remove it, such as glacial acetic acid, hydrargyrum bichloridum, etc. How much success will attend the treatment, it is, however, difficult to say. Nevertheless, it could well be tried.

ACUTE CIRCUMSCRIBED ŒDEMA.

V. G—, age thirty-three, Frenchman, waiter by occupation. Patient states that the affection began in the fall of 1876 and that he was at the time healthy, except that he suffered more or less from gastric catarrh. He had never had syphilis or any serious sickness.

At first the attacks only came twice a month, and an increase in their number did not occur until two years ago, when they appeared sometimes twice weekly, sometimes three times weekly, and even every day. Quite frequently he feels heavy and sleepy previous to an attack. He is usually costive and suffers from indigestion.

The œdema does not recur in the same place all the time, but any portion of the body may be affected—an entire lower extremity, or the face and scalp, etc. The symptoms are œdematous swelling and a sensation of itching and burning. There is no change in the color of the skin, except occasionally when it is slightly reddened. After persisting for some hours or an entire day, or longer, the swelling disappears as rapidly as it originated.

I first saw the patient on December 8, 1886, at which time the thigh was the portion of the body affected. The symptoms which were present were those just given as characterizing the affection. At the same time, he was very costive and complained of nausea, gastric malaise and felt dull and sleepy.

I prescribed for him *cascara sagrada* and *nux vomica*, and when I saw him again on December 10th, the œdema was gone and the bowels were regular. The same treatment was continued and he did not have another attack until December 27th, on which date the swelling appeared in right foot and back of left thigh. He had neglected himself and had been three days without a movement from his bowels. I gave him again the same mixture of *cascara sagrada* and *nux vomica*. I saw him from time to time for several months after and observed that attacks still occurred, but they were diminished in number as well as in intensity, and as long as he attended properly to his general functions, he experienced little trouble from the affection.

It can be said that the only symptoms of this curious affection, acute circumscribed œdema, is the œdema, which, originating quickly, lasts a short space of time and then disappears, It affects any part of the body, perhaps most commonly the face, and even the glottis and larynx. It is sometimes accom-

panied by general systemic disturbance, somnolence, vomiting, gastric, intestinal and renal symptoms, sometimes without any of these.

Its diagnosis offers no difficulty whatever, owing to its transitory characteristics, and consequently it could not be confounded with those persisting oedematous conditions which occasionally owe their origin to precedent attacks of erysipelas or of eczema.

The treatment of this form of oedema must be entirely empirical, inasmuch as its origin, though ascribed to the nervous system, is still obscure and wanting in proof. Possibly the best line of action will be that of correcting any deviation from the normal existing in regard to the general functions and of placing the entire body in the best possible condition of health. Matas, of New Orleans, reports a case which occurred periodically every day and which was completely cured by large doses of quinia; the case, which is reported here, improved immediately as soon as the bowels were regulated and the stomach brought into proper condition, so that it would seem as though the symptoms characterizing acute circumscribed oedema, at least in these two, were more or less dependent upon some disturbance present in the general economy. There are other means of treatment which have suggested themselves to me, but their mention would necessitate a general review of the entire affection, and I will rather reserve their enumeration until a more suitable occasion.

#### TREATMENT OF EPITHELIOMA WITH LACTIC ACID.

Case 1.—Mrs. R——, age seventy-six, states that affection began four years ago. Its course has been a typical one and it has grown larger slowly, remaining perfectly superficial. It is situated on the left side of the bridge of the nose, extending towards the inner canthus of the eye, and when she consulted me, March 11, 1886, the ulcer was about as large as a nickel, oval in shape and had the general characteristics of that form of epithelioma termed rodent ulcer. On March 14th, I applied the lactic acid and allowed it to remain for twenty-four hours. After removing it, the wound was dressed with boric ointment. On March 17th, the slough was cast off, granulation and cicatrization progressed rapidly and by the 25th was completed. The scar which remained was very slight and was smooth and soft. Since that date there has been no return of the disease.

Case 2.—W. B——, age thirty-eight, came to me in February, 1886, with a superficial ulceration upon lower lip, just to the right of the median line. It had been present for two and

one-half years, crusting over at times, and it had become as large as a bean. Its objective symptoms were characteristic of an epithelioma, and, owing to its being so superficial, I determined to use lactic acid.

The acid was applied in the same way as in the preceding case, but one cauterisation was not sufficient, three further applications being necessary before the disease was eradicated. In six weeks, however, the lip had healed completely and there has been since then no return.

Lactic acid was suggested by Mosetig-Moorhof, of Vienna, for the treatment of epithelioma, and was used by him in those cases of the disease which were inoperable. He claimed to obtain most gratifying results from it, and, in fact, demonstrated its value in several cases which had been considered as being beyond aid. It has, however, not superseded other caustics in vogue with the profession in general, notwithstanding that it does at times give good results. I do not think it should be used any more than any other caustic, except in very small superficial epitheliomata, the growth of which is very slow, or when surgical treatment is absolutely objected to. In my opinion the treatment of epithelioma should always be the knife, as it is the only means which gives promise of the possibility of total eradication of the disease; but when this is not possible, lactic acid may be made use of with probably as good results as will be obtained from any caustics.

I have employed it, as Mosetig recommended, in combination with silicic acid,—Lactic Acid, 2 parts, Silicic Acid, 1 part. After protecting the healthy skin surrounding the lesion with any bland salve, the caustic is applied over the entire diseased surface and covered with gutta-percha paper, which may be retained in position by strips of isinglass plaster, or where practicable by means of a bandage. The action of the caustic is very painful, and for that reason I have always applied it at bedtime, giving the patient a large dose of bromide or morphia to produce sleep. The result has usually been good, only little pain being felt.

The acid is allowed to remain on the lesions for about twenty-four hours and after its removal the wound dressed antiseptically. The slough having been cast off, a healthy granulating surface is usually found, cicatrization ensues and the epithelioma has been destroyed. It may, however, be necessary to repeat the application several times before healing takes place. Relapses occur as frequently and as rapidly as after the use of any other caustic.

## TUMOR OF THE BLADDER—REMOVAL—RECOVERY.

BY

ALEX. W. STEIN, M.D.

Surgeon to Charity Hospital.

**M**ALE, age forty-six, single, admitted to my service September 14, 1887.

Patient's trouble rests upon the tripod of symptoms, irritable bladder, hematuria and pain. Has been suffering at least four weeks. He states that the irritability of the bladder, as evidenced by the frequency of the desire to micturate, preceded the appearance of the blood about ten days. The bladder became more and more annoying until the present time, when the desire to void urine is at varying intervals of from five minutes to three-quarters of an hour. Pus gradually made its appearance in the urine and subsequently blood. The pain is associated only with the final act of micturition, during the expulsion of the last drop of urine, and extends along the urethra to the glans penis, being especially severe when clots have formed and accumulated in the bladder. The urine is tinged from the common current of the flow, but that which comes last invariably contains blood.

The hematuria has not been intermittent, it has been continuous from the time of its first appearance, nearly three weeks ago, until the present time, though there has been an increase in the quantity of blood passed. It is now more than a parenchymatous hemorrhage, at times it is quite free, and the urine contains numerous and large clots. Indeed, the blood lost did not prove to be commensurate with either the size or the character of the tumor; urine is acid and contains pus and blood, a trace of albumen not more than would be accounted for by the presence of the aforesaid abnormal ingredients. No evidence was obtained from physical examination per rectum, by bimanual palpation or by catheterization. Urethra reveals no abnormality. The urine is equally negative, although several specimens, passed at different times, were carefully examined.

As no data were obtained by these means, and as remedies given to arrest the hemorrhage were without avail, digital exploration was decided upon. September 17, 1887, patient being under ether, and a grooved staff passed, I made an incision in the median line of the perineum about an inch and a half in length, the lower angle of the wound terminating about three-quarters of an inch anterior to the anus. On introducing my right index to the cavity of the bladder, and by mak-



ing supra pubic pressure with the left hand, I encountered what appeared to be a fibrous polypus projecting into the interior of the bladder as a globular or pyriform mass, somewhat larger than half a horse-chestnut. The tumor was not distinctly pedunculated, but was rather an outgrowth from the vesical wall. It was firm, smooth and situated on the posterior wall of the bladder to the left of the patient's median line. It was quite high in the cavity of the bladder and was rather inaccessible, but as much of the tumor as was possible was scraped or curetted away, expecting to resort to the supra pubic operation for the more radical extirpation of the mass, should it recur. The growth was scraped away piecemeal by pressing it against the edge of the curette with the finger. There was free hemorrhage in consequence of the scraping, which was controlled by injecting into the bladder a solution of iron perchloride.

Patient rallied promptly. In the evening there was considerable hemorrhage from the bladder, and patient complained of pain in penis with a constant desire to urinate. He was given morphia hypodermically September 18th. Slept comfortably last night; is feeling quite well, and still complains of the pain in the penis, and the frequency in micturition. The hemorrhage has ceased, but there is a small quantity of blood in the urine occasionally. Ordered inf. buchu, ext. hyoscam. and potass. citrat, September 21st. Patient held his water three hours to-day. He passes it mainly *perviam naturalem*, partly through perineal opening. No pain in penis. September 23d. Passes urine entirely through the urethra. No more blood in urine. September 30th. Perineal wound almost closed; no trace of blood since 23d inst. Patient has had no constitutional disturbance whatever since the operation. He has felt well, with his appetite unimpaired.

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#### THE TREATMENT OF EPITHELIOMA WITH MILD CAUSTICS.

BY

DANIEL LEWIS, M. D.<sup>1</sup>

STATISTICS from the London Cancer Hospital from 1851 to 1872 show that of 8579 cases of cancer, 2010, or more than twenty-five per cent., were surface epitheliomata.

Next to scirrhus tumors then come these cases, which, whether properly or not, have been considered within the field of dermatology. Although what I shall claim to be the effect of mild

<sup>1</sup> Read before the New York Dermatological Society.

caustic application applies with greater force to the more malignant varieties, such as epithelioma of the tongue, rectum and cervix uteri, it is to those directly affecting the skin to which attention is directed in this paper.

It is well to consider briefly some of the characters belonging to this group. The majority of patients are men, and in most cases the disease is located in some portion of the face, the side of the nose, on a level with the angle of the eye, being so frequently affected as to be almost justly termed the point of selection for these cases. The disease seldom begins until middle age has been passed, when the vital forces are declining, and some local irritation is often the exciting cause in this locality, as is almost invariably the case in cancer of the lips. During the past year I have treated one which developed in the callosity resulting from the pressure or rather pinching of eye-glasses, and also another epithelioma occurring on the dorsum of the nose, where an old-fashioned spectacle bow had rested for many years.

The disease spreads in the direction where it meets the least resistance, that usually being in the skin only, the underlying tissues becoming very slowly affected. Even the eyeball often resists the disease until both the lower and the upper lids have been destroyed. The *natural* course of the disease is exceedingly slow except in those parts composed of loose, non-resisting tissues, such as the lip, vulva, penis and scrotum.

Virchow says of it that "it remains for a long time local, so that the nearest lymphatic glands often do not become affected until after the lapse of years, and then again the process is for a long time confined to the disease of the lymphatic glands, so that a general outbreak of the disease in all parts of the body does not take place until late, and only in rare instances."

The photograph of the patient, I here present, shows the progress of the disease in seventeen years, *without any medical or surgical interference whatever*, which is the most remarkable part of his history to me, for we very seldom see a case of cancer for which something has not been ordered by a physician, or some better qualified person, to promote a cure.

In comparing the characters just enumerated with those of cancer of other organs than the skin, it becomes apparent that these superficial, slowly infectious, and I might add nearly painless affections, are naturally the most curable of all the cancerous diseases. I say *naturally* the most curable, because, as we find these cases in practice, they are very often *deep* in surrounding tissues, *rapidly* infecting neighboring lymphatic glands,

giving rise to *considerable* pain, and *rapidly* advancing to a fatal termination, and all this the result, as I believe, of the mild cauterization which is employed in nearly every instance in the early history of the case.

By the term mild cauterization, I mean all caustic applications of whatever kind which aim at a *gradual* destruction of the diseased tissue. A few cases will illustrate my meaning. A young man of thirty years consulted a physician about one year ago for a "cracked" lip which had troubled him two or three months. During the next six months eighty applications were made to the lip, so the patient says, of a caustic answering to the description of nitrate of silver. The result is the entire lower lip cancerous, an enormous tumor on the left side of the face and inferior maxillary region, which has ulcerated in several places, and the "cancer cachexia" of the older writers indicates an early fatal termination. This very unusual glandular infection can only be accounted for by the fact, as I believe, that the repeated applications acted in the same manner as the local irritation which is so often the exciting cause of the primary disease.

An old lady, who was under my care while I was connected with Dr. Bulkley's service at the Skin and Cancer Hospital, suffered from an epithelioma of the ala nasi on the right side, and a small one on the cheek of the opposite side. The latter was thoroughly removed by curetting, after which a strong pyrogallol acid ointment (3 iv-3 i) was applied for three days and the ulcer healed without delay and never recurred. The *curetting* removed *all* the disease, and the ointment, acting as a stimulant to the surrounding blood supply, actually hastened the granulation process.

The larger epithelioma on the nose was curetted, the ointment applied and the disease sprung up anew. The strength of the ointment was increased until the pure acid was several times applied, and finally, after months of the most faithful trial of the plan I ever witnessed, the case was treated surgically and a prompt cure rapidly effected.

In this latter instance *all* the disease was not removed by the curette, and the mild caustic application stimulated the growth of the remaining cancer elements.

In a large number of cases which I have observed, where the pyrogallol was used, the same unsatisfactory results followed, so that, in my judgment, it can only be useful in those semi-malignant ulcers of the skin which have no elevated or indur-

ated borders, while in the ordinary epitheliomata its use is not alone useless but positively injurious.

The successes with pyroyallol and resorcin are so exceptional that their use to such cases should be discarded altogether.

Nitrate of silver is one of the most frequent of mild applications and also one of the most injurious.

It is probable that no epithelioma of the tongue ever escaped an application of this remedy, and it is equally certain that no case was ever benefited thereby.

Without multiplying instances of such meddlesome treatment, let us consider the effects of such applications upon the healthy skin. The epidermal layers are promptly destroyed; but as they contain no power to carry diseased cells into surrounding tissues, their safety or destruction does not concern us now. The changes in the true skin are those belonging to simple inflammation, viz.: hyperæmia with engorgements of the affected parts with blood, swelling, redness, pain, often œdema resulting from stasis in the vessels, and *increased activity* to the tissues, with tendency to new products.

It cannot be doubted that the blood vessels and lymphatics are absolutely essential to a healthy propagation, if I may use the term, of the cancer elements, in the skin as elsewhere in the body. In the case represented by the photograph, œdema of the upper lid caused by the destruction of its blood supply at the angles of the eye was an insurmountable barrier to the progress of the disease in that direction for many years.

Given a area of skin infiltrated with malignant disease, and then stimulate all the activities of adjacent tissues, and only one result can follow—a greater degree of activity to the diseased area. This brings us to the laying down of this proposition, justified by experience as well as philosophy :

*No mild caustic application should ever be made to any cancerous surface under any circumstances.*

Only such caustics are admissible as *completely* and *rapidly* destroy the diseased tissues—such remedies destroy the vessels and lymphatics adjoining and so prevent dissemination of cancer elements.

An exception should possibly be made in favor of one mild remedy, the galvanic current.

Julius Althaus recommended its use in a paper published in 1869, and several writers have since advised its use in these cases, prominent among whom was the late Dr. Beard of this city. It is not as a caustic, however, but by the chemical action of the negative pole, attached to a five-celled battery, that a marked change in the diseased tissue has been effected which terminated in complete cure in several instances. My own experience is too limited to enable me to express an opinion, but a few applications made by Dr. Fox in a lower lip which was extensively diseased caused a very decided softening and shrinking of the growth. The case is an incurable one, or I would insist upon a very thorough trial of the remedy.

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## **Society Transactions.**

### **THE NEW YORK DERMATOLOGICAL SOCIETY.**

#### **THE 176TH MEETING.**

**DR. ROBERT W. TAYLOR, *President, in the Chair.***

**DR. BRONSON** presented a case of

#### **ELEPHANTIASIS OF THE LEGS**

The patient was a young married woman of about twenty-five years of age, a native of Austria, who had first noticed the disease when she was twelve

years of age, though the chief increase in size had taken place within a year. During this time there have been several attacks of acute inflammation of the legs, probably erysipelatous. The right leg was larger than the left. Some of the swelling was oedema, and the legs were not so large in the morning as at night. The surface of the skin was normal. No cause could be discovered for the elephantiasis. The curious circumstance was noticeable that the patient's mother had also suffered from the same disease, and that in her case also it began in childhood. Dr. Bronson stated that he hoped to get an expression of opinion on the case from the members of the Society.

DR. BULKLEY thought that the symptoms in the case were due principally to lymphatic oedema, as there was pitting on pressure. He would consider it an example of pseudo-elephantiasis.

DR. SHERWELL spoke in relation to the classification and etiology of elephantiasis Arabum. He wanted to know if there was any distinction, save a clinical one, between the hyperplasia caused by the presence of the filaria (according to Manson and others) and those resulting from or produced by other causes. Is the disease caused by the filaria the only true elephantiasis or not? As for himself, he was inclined to take the view that any stoppage of the lymphatics, occasioned by any cause and accompanied by hypertrophy of the skin and connective tissue, was entitled to the name. He well remembered seeing that striking case given by Dr. Fox in his first book of Plates, and also remembers that its history was that of a sequel to scarlatina.

Comparatively recently he had had a case under observation at the Brooklyn Hospital in the person of a woman of Irish birth and long residence in the United States, but who had never visited other countries. In this patient acute erythematous or erysipelatoid attacks, similar to those described by Manson, were very marked and at very regular and frequent intervals. Her blood and tissues had been carefully examined under the microscope by himself and another very competent microscopist at the typical times for the appearance of filariæ, but these latter were never found.

DR. KEYES called attention to the apparently hereditary tendency presented by this woman, as her mother had had also big feet. He also thought that the prognosis in this case was good, since the affection had already been present ten years and there was so much oedema. Dr. Keyes said that when, some years ago, he was collating dermatological cases he had come across the report of a patient who had suffered from elephantiasis, but had been cured by use of a starch bandage, which had been worn for about a year. The patient had not only gotten well of the elephantiasis, but atrophy of the leg had followed. He was unable to say, however, whether this condition remained a permanent one. He thought, that in this case the treatment indicated was rest in bed and application of the rubber bandage for twenty-four or forty-eight hours, and then a silicate of soda bandage. This latter should be changed about every four weeks, and its use persisted in for six months or a year.

DR. STURGIS referred to a case of elephantiasis in Charity Hospital, some years ago, and also asked what were the results obtained in elephantiasis from ligation of the femoral artery.

DR. KEYES stated that temporary improvement was always observed, but that the disease progressed again after a time.

DR. ALLEN mentioned a case of elephantiasis which he had seen and treated for some time, about fifteen years ago. It was of an aggravated type and extended to the knee. The skin was thrown into folds which encircled the leg, and, upon these were smaller openings from which a thick molasses-like fluid exuded. Deep ulcers were also present. He had been surprised

to learn during the past year that the disease was almost cured. He had at present a case under treatment in Charity Hospital, which, on the toes, presented thick, hard and warty growths. The leg had been treated by compression with the rubber bandage and some improvement had been obtained. It was now being applied to the foot and toes, each toe being bandaged separately. The bandage has, however, to be left off from time to time. Dr. Allen said that Dr. Bronson had seen the case and knew about it, so that he would like to know his opinion in regard to it. True cases of elephantiasis which had been seen by him had not acted in this way—that is, had not improved so much under simple treatment, but tended rather to go on from bad to worse.

Dr. BRONSON, in summing up, stated that he did not think it justifiable to speak of a true and a pseudo-elephantiasis. He thought that any disease in which lymphatic swelling was a feature could produce elephantiasis. It was probable, however, that when true elephantiasis was referred to, that caused by the presence of the filaria was meant, yet it was well known that the affection developed also in connection with old chronic syphilitic gummata, with eczema and with erysipelas.

The present case, however, did not enter into this category. It might be the result of a chronic phlebitis or lymphangitis, and at her age it might be expected that the collateral lymphatic circulation would relieve the obstruction to the passage of the lymph and remove the affection.

Dr. BRONSON remembered seeing the case referred to by Dr. Sturgis, and was present at the time the leg was amputated. The patient had been accustomed for about a year to lie in bed with the leg hanging over the edge, and could not be induced to change its position. The enlargement of the leg was enormous, but he could not see any lymphatic enlargement after its removal; it seemed to consist mostly of adipose tissue. A few months after the amputation the disease began in the other hitherto sound leg; that was also amputated, but the patient died.

Dr. TAYLOR mentioned having had a case shown him last May at the Roosevelt Hospital Dispensary. The patient was a woman with elephantiasis of the leg, beginning at the ankle and extending to the knee.

The paper of the evening on

THE TREATMENT OF EPITHELIOMA WITH MILD CAUSTICS (See page 23.), was then then read by Dr. DANIEL LEWIS.

Dr. BRONSON made objections to the disparaging remarks of the reader of the paper with regard to the value of nitrate of silver as a caustic agent in the treatment of epithelioma. Employed only superficially, it was admitted that its effect would be merely trifling, but when the fused and pointed stick was used after the manner of Hebra, boring into the new growth in all directions, it became a most efficient and valuable caustic. Dr. Bronson was positive that he had obtained most excellent results from its use. There might be a recrudescence of the disease, but often not for years, and sometimes not at all. This method was especially valuable when it was important to preserve sound tissues, as, for example, in the regions of the eye.

Dr. CUTLER stated that he had also seen very good results from the use of nitrate of silver.

Dr. BULKLEY said that he would agree with Dr. Bronson, that under the circumstances last mentioned by him, nitrate of silver was sometimes useful when thoroughly used by boring in. Yet he did not think that in the majority of cases any of the members of the society would use mild caustics in the treatment of epitheliomata. He wished to add that the case of the old lady seen in his clinic and mentioned by Dr. Lewis in his paper, had not been cured by the surgical operation, as the disease had returned and now the nose was entirely gone and an open ulcerating cavity left.

DR. ALLEN thought that strong caustics were more necessary than mild ones. Still he agreed with Dr. Bronson in regard to the occasional value of the nitrate of silver stick. He had at times used mild caustic on a small spot after the disease was apparently cured, and it would remain well at this point while small nodules would return elsewhere. Resorcin he thought had also some points in its favor, and gave good results. Dr. Allen spoke further of these epitheliomata, which, although very superficial upon the skin, yet when occurring in the space between the inner canthus of the eye and the nose, dipped deeply down, destroying all the tissues. In these, he thought, mild caustics were of use after the surface had been scraped.

DR. SHERWELL said that he had seen many cases of the disease and from his experience he agreed with Dr. Lewis, that the stronger escharotics were the best. The destruction of more tissue caused by their use was of little account in comparison with the danger of recurrences. In regard to nitrate of silver, it was his impression that Hebra used it more in lupus than epithelioma.

DR. MORROW concurred in the main with the proposition made by Dr. Lewis, that the use of mild caustics was, as a rule, injurious in the treatment of epithelioma. Still, he thought that his statement, that all mild caustics should be rejected as inefficient or harmful, was too absolute and sweeping. He had seen cases of rodent ulcer undoubtedly benefited by the use of mild caustics; by such means the progress of the disease was checked and kept in abeyance for some time. The fact cannot be ignored that many cases of epithelioma have been reported by careful and competent observers as cured by chlorate of potash. He had seen a list of sixty cases, the majority of which had been cured by chlorate of potash, and Fournier reports cases of this character in late numbers of the *Gazette des Hopitaux*.

There were unquestionably great differences in the malignancy, the rate of progress, and other characters of superficial epitheliomata. Some developed rapidly and were not modified by the application of mild caustics, others were slow in progression and could be markedly benefited or cured by such means. He had used strong solutions of chlorate of potash and of chloride of sodium, and weak ones of chloride of zinc, on inoperable cases, and he had thought that their rate of progress had been markedly diminished. As a rule, however, he would not advise the use of mild caustics as the best form of treatment, owing to their stimulating action.

DR. KEYES stated that his predilections in regard to the treatment of epithelioma were entirely surgical and not dermatological. He thought the use of mild caustics was merely a form of pottering with an affection which, as soon as diagnosed, should be radically attacked. In cases which were inoperable, however, some benefit might be obtained by the use of mild caustics in keeping the disease more or less within limits.

DR. STURGIS was of the opinion that thorough destruction of the disease was absolutely necessary, and for this reason mild applications were dangerous. The use of nitrate of silver he thought was accompanied with too great risk; still, it might, perhaps, be serviceable when the disease was very superficial.

DR. ELLIOT stated that he believed with Dr. Keyes that the treatment of epithelioma ought to be surgical. In very superficial lesions, however, which presented no evidences of active progress, caustics might be used. He had treated two cases of rodent ulcer, one on the nose and the other on the lip, with lactic acid, nearly two years ago. They had healed and the patients had remained well up to the present day. He had also used resorcin with, apparently, very good results, but only within the last few months, so that he could not say, absolutely, what success could attend its application. When a case of epithelioma was inoperable, he did not think it made much difference what was used, whether mild or strong caustics, since the treat-



ment could only be a palliative one. Of nitrate of silver alone, he did not think much, but would only use it to destroy very small spots which returned in cicatrix resulting from an operation for removal of a growth or from some other treatment.

DR. LEWIS, in summing up, stated that he knew that the case referred to by Dr. Bulkley was suffering from a return of the disease. Still it had healed rapidly after the surgical operation and had remained well for some time before the return of the epithelioma. He said further that, notwithstanding it must be granted that some cases of epithelioma had been cured by nitrate of silver, yet he thought that a more energetic caustic would do better. He did not regard chlorate of potash as a caustic. He had used it in form of powder, dusting it on large ulcers week after week, but he never obtained any other result than that of improving the appearance of the wound. Dr. Lewis regarded lactic acid not as mild caustic but as a strong one.

The Society then went into Executive Session.

## Correspondence.

### DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

#### Nomenclature of Skin Diseases.

DR. ROBERT LIVEING's excellent address on this subject will hardly bear to be briefly epitomized. (*Brit. Med. Journal.*)

His chief conclusions are: (1.) That obsolete names should be dropped. *Porriago* is an instance of one which has just died out. *Pityriasis* should be dropped, the four diseases for which it stands being better called by other names. *P. simplex* is no distinct disease; *P. rubra* is now known as dermatitis exfoliativa; *P. versicolor* should be called *Tinea versicolor*; *P. maculata et circinata* (Bazin) is too long, and Behrend's name, "roseola 'furfuracea herpetiformis'" has the same fault. *Roseola circinata* is suggested as a good name for this distinct though not common disease [also called pityriasis rosea of Gibert].

(2.) Coincident skin diseases are rare, but when they exist are quite distinct, and should never be described as *mixed* diseases. There are no truly mixed or hybrid skin diseases. Hence, such names as lupus-psoriasis, lichen-psoriasis, varicella-prurigo, etc., are objectionable.

(3.) Syphilitic skin diseases differ from ordinary skin diseases in their etiology, pathology and treatment, and these differences should be fully recognized in our nomenclature. Hence, such names as syphilitic lupus, syphilitic psoriasis, and the like, are erroneous, even if sometimes convenient, and are especially puzzling to beginners.

(4.) Eruptions produced by drugs or medicinal rashes are not true *diseases* of the skin, but eruptions, and should be so named. For instance, the bullous form of eruption from potassium iodide should not be called pemphigus (as by Bumstead), or hydroa (as by Hutchinson), but merely "blebs from iodides." No one supposes that the actual diseases named above can really be produced by drugs.

#### Symmetrical Gangrene following Varicella.

A case reported by Mr. Bellamy to the Clinical Society of London (*British Med. Journal*) of fatal diffuse symmetrical gangrene after varicella

in a child aged four, was presented as one of Raynaud's diseases ; but the general opinion of the meeting was that it was not this disease, nor yet varicella gangrenosa as commonly understood, but rather one of gangrene occurring in the course of an exanthem, of which complication other cases were quoted.

#### **Dermatitis Gangrenosa Infantum.**

An elaborate paper on an allied subject was read to the Medical and Chirurgical Society by Dr. Radcliffe Crocker, which will appear in the Transactions. Dr. Crocker distinguishes four groups of cases. In the first there was no history of varicella. In the second (and largest) group, varicella had preceded the sloughs or ulcers. In the third group vaccination was the immediate antecedent, the fourth included certain cases of local gangrene resembling cancrum oris. Any further account may be postponed till the printed paper appears.

#### **Bullous Eruption Occurring in Acute Rheumatism while Treated with Sodium Salicylate.**

Dr. F. L. Benham has published (*Lancet*) a curious instance of this. A typical case of acute rheumatism was being treated with sodium salicylate in full doses, and on the third day the joint affection was subsiding, when an eruption appeared, at first in the form of "pale, soft, blunt conical papules, the size of large peas, on backs of hands, knees and ankles. These became bright red, flatter and larger, up to the size of a shilling or more, and spread all over the body. Some healed in the centre and became ringed. Beside these patches there were on the lower lip, closely set vesicles like those of herpes ; and on various parts of the body, larger solitary vesicles with bullæ. Some of the bullæ were very large, and on breaking formed superficial sores. The erythematous patches presented, after a time, the appearance of *E. annulatum* and *E. gyratum*. The eruption lasted about a fortnight and slowly subsided, but remained some days after the rheumatism had disappeared. There was intense itching.

Dr. Benham regards the eruption as a form of erythema multiforme, but points out that it also agrees with the description of hydroa bullosa (Bazin). It was clearly distinct from pemphigus and did not resemble erythema nodosum.

This would seem to have been a more severe form of erythema than is usually observed in rheumatism, though slight forms are not very uncommon in that disease. The suggestion was made that the sodium salicylate might have produced the eruption, and another correspondent of the *Lancet*, Mr. Cochrane, avers that he has seen a similar eruption produced by that drug.

#### **Prurigo Hyæmalis or Frost Itch.**

J. F. Payne records (*British Med. Journal*) four cases of intense itching which occurred only in cold weather, similar to those described by Duhring in 1874 and Hutchinson in 1875. The affection in all cases began in November and December, and lasted till March or April in the winters 1885-6 and 1886-7. As the winters preceding 1885 had been for some years very mild, in London, possibly that might explain the fact that so few cases of this affection had been recorded since it was first described. .

#### **Affections of the Nails.**

Mr. Jonathan Hutchinson describes (*British Med. Journal*) several

forms of disease of the nails. The first "*psoriasis*, of the nails" occurred in a man. The nails were not thickened, but merely loose, dry and opaque. Those of both hands and feet were affected. The patient had typical *peoriasis* of knees and elbows. The affection both of skin and of nails had lasted some years and came on in attacks, but often got well spontaneously.

Contrasted with this was the case of a lady who suffered from chronic *onychia* attended by fibrous thickening of the nail itself. She suffered from *eczema* elsewhere.

Two cases of affections of the nails in children, with a bare suspicion of inherited syphilis, are also described.

### Solitary Melanotic Sarcoma of the Skin.

Dr. Allan Jamieson, of Edinburgh, in describing a case of this affection (*Edinburgh Med. Journal*), remarks, that solitary growths of this kind are much rarer than multiple growths, which have been often recorded. The patient in question was a woman aged twenty-six, in 1881, who had had, ever since she could remember, a black mark on the right shoulder. When she was ten years old, it was perhaps half an inch across, but being then struck with a stick, it began to grow, and had reached three times that diameter. It was then of a deep bluish-black color, little raised above the skin-level, and having the appearance of a pigmentary *naevus*. It was removed by scraping and the fragments on examination were pronounced to be those of a blood clot under the skin. Four years later the patient returned with a lump, said to be of two months' growth, in "the form of a fungating black nodule the size of a walnut." This was very completely removed by excision, including the scar of the former operation, and found to be a round-celled melanotic sarcoma. There was no local recurrence of the growth, but in about a year cerebral symptoms came on, pointing to metastasis of the tumor, and after death, which took place just a year from the operation, numerous secondary growths of melanotic sarcoma in the brain, and also in some other organs. The full pathological description, by Dr. Byron Brainwell, with numerous figures, need not be considered here.

### Double Comedones.

Dr. A. Jamieson exhibited to the Medico-Chirurgical Society of Edinburgh (*Edinburgh Med. Journal*) a man aged twenty-nine with *acne* of the back and shoulders, having previously suffered from the same complaint on the face. The comedones were particularly large and a peculiarity was at once observable, viz.: that many were set regularly in pairs, like spots on dice. When they were pressed laterally, a large plug of thickened sebum, with a black head at either end, was forced out, thus showing an anatomical connection between the ducts of two sebaceous follicles. This curious condition, which was not pathological but physiological, was first described by Ohman-Dumesnil of St. Louis, in the *JOURNAL OF CUTANEOUS AND VENEREAL DISEASES* for 1886. The anatomy of the condition has not been worked out.

### Seborrhœa Corporis.

T. Colcott Fox, writing on *lichen annulatus serpiginosus*, of Erasmus Wilson, represented in his "Portraits of Skin Diseases," 1847, shows its identity with *seborrhœa corporis*, described by the American Dermatologists, Van Harlingen, Bulkley and Duhring, and thinks the latter name should be

adopted. He gives several cases of the combination of seborrhœa of the trunk, face and scalp. (*British Medical Journal*.)

J. F. Payne (same journal) claims priority for the name *Lichen circumscriptus*, given by Willan in 1808, and illustrated by a figure. He also justifies the name (*Flannel Rash*) given to this affection at the London Hospital for Diseases of the Skin, and thinks the name seborrhœa inadequate, since there is inflammation of the sebaceous glands and not merely over-secretion.

P. H. Pye Smith (same journal) corrects the statement that he regarded this affection as a kind of eczema. He thinks it is not a glandular disease, but a form of papular dermatitis or lichen, best called *L. circumscriptus*. (In Dr. Liveing's recently published fifth edition of his "*Hand-book of Skin Diseases*," this affection is classed under the head of *Steatorrhœa, i. e., Seborrhœa*.)

### **Purpura Hæmorrhagica.**

Dr. Mouillot communicated to the Academy of Medicine in Ireland (*Medical Section*) two fatal cases of this disease. One died in a few days from weakness of the heart, producing œdema of the lungs. In the second case, which was remarkable for the difficulty of restraining bleeding from the gums, the patient died after seven weeks' illness, from cerebral hæmorrhage.

### **Pityriasis Rubra.**

Dr. Wallace Beatty reported to the Academy of Medicine in Ireland a case in a woman aged seventy-one, who had suffered for one year.

The disease began on the inside of the thighs, and spread thence to legs, body, arms and face. The skin was universally red, and generally covered with thin, dry papery white scales, entirely dry and consisting of exfoliated epidermis, which could be peeled off without pain. They were wanting, or scanty in the axillæ and other flexor surfaces. The face presented a remarkable tightened appearance, from the parchment-like condition of the skin, which was only cracked (not exfoliated), and a similar condition of skin was visible on the fingers and toes. There was a temporary eczematous condition at the back of one ear, which soon disappeared. The subjective sensations were slight itchiness; but there was also some delirium. The patient was treated with potassium bromide, and rapidly got better, being discharged in five weeks, practically well.

The case was discussed by Drs. Finny, Walter Smith, Mapother, and others, who agreed as to the extreme rarity of the affection, but differed as to whether it should be considered a substantive independent disease. The name dermatitis exfoliativa was generally preferred.

### **Pityriasis Rubra.**

Sir Dyce Duckworth gave an account to the Clinical Society of London (*Brit. Med. Journal*) of a case of ordinary psoriasis associated with rheumatism in which the skin affection passed into general exfoliative dermatitis. The patient was a married woman, aged twenty-four, the mother of one child which she had suckled for four months. She had had rheumatic fever when a child, and had suffered from ordinary psoriasis on three occasions, and each time rheumatic symptoms had accompanied the skin disease. When admitted into hospital, the psoriasis was passing into a general desquamative dermatitis and the rheumatism was getting

worse. The temperature ranged from 100 to 103.8° F. During three months' stay in the hospital, the patient was first treated with sodium salicylate combined with low diet, but without effect. Arsenical treatment, on the other hand (Liq. Sod. Arseniat. B. P. *m. x. t. d.*), combined with full diet, had excellent results, and the patient went out with the skin quite cured, but the joints still stiff and crippled, especially those of the hands and wrists. The rheumatic affection did not precisely conform to the type either of true rheumatism or of chronic rheumatoid arthritis; and Sir D. Duckworth expressed himself doubtfully as to its nature.

#### Rhino-Plastic Operation Subsequent to Cure of Lupus.

T. M. Girdlestone describes (*Australian Medical Journal*) an operation for the restoration of the nose after the cure of lupus which had destroyed it. The disease had been completely cured by scraping and caustics, but the septum with the whole of the right ala nasi, and a great part of the left were destroyed, and the remnant of the nose reflected backwards. The hard palate was also perforated.

Girdlestone followed Syme's method, reflecting a thick flap of skin from either cheek. The remnant of the nose was also utilized, the flaps being brought forward and united with this. Lateral pressure was then applied by means of a species of small double truss.

If we may judge from the photographs published, the operation must have been very successful.

#### Erythema Nodosum in Connection with Rheumatism.

Dr. Stephen Mackenzie has tabulated the particulars of one hundred and eight cases of erythema nodosum collected from the records of St. Thomas's, Guy's, St. Bartholomew's and the London Hospital, especially with reference to a combination with rheumatism. He found in thirteen cases acute, and in four sub-acute rheumatism recorded as co-existing with erythema.

In seventeen other cases, joint pains, apparently of a rheumatic character, were present. In three of these cases there was a history of previous rheumatism, and in four, evidence of heart disease, in two "sore throat," and in two a family history of rheumatism.

Thus, if it be assumed that these seventeen cases were all rheumatic, there would be 34, or 31.4 per cent. in which E. nodosum was associated with some kind of rheumatic affection.

In twelve other cases the patient was said to have previously suffered from rheumatism. In eleven other cases there was what was called a family history (but this of almost no value in the case of ignorant patients).

In ten cases a cardiac murmur without history of rheumatism was present; and in five besides these, murmurs apparently due to endocarditis came on during the attack of erythema.

The general conclusions were :

- (1.) "That E. nodosum is frequently associated with definitely rheumatic symptoms, *e. g.*, arthritis, sour sweats, sore throat, etc."
- (2.) "That heart disease (endocarditis) may arise during an attack of E. nodosum, with or without joint inflammation."
- (3.) "These conclusions justify the inference that E. nodosum is frequently, if not generally, an expression of rheumatism, even when no definitely rheumatic symptoms are present." (*Clin. Soc. Trans. XIX. 215.*)

### Late Inherited Syphilis, Gumma of Liver with Hectic Temperature.

Dr. Bristowe records (*Clin. Soc. Trans.* XIX. 249) a case interesting as regards symptoms and difficulty of diagnosis. A boy aged fifteen was admitted to St. Thomas's Hospital from a localized tumor of the liver, and at the same time from pyrexia of rather peculiar type. The temperature was usually subnormal in the morning, ranging from 95.6° to 97° F., and rising in the evening to a height of 100° to 103°. There was no history pointing to syphilis, and no positive diagnosis was made. An exploratory puncture gave entirely negative results. On more minute investigation of the eyes, however, evidence of past syphilitic keratitis was obtained, and a history of an affection of the eyes at seven years old. Under the guidance of these results antisyphilitic treatment was adopted, consisting in the administration of five grains potassium iodide with thirty minims solution of perchloride of mercury (B. P.) three times a day. After four days of this treatment, the temperature which had been febrile for ten weeks, became normal; and after that subnormal, not rising to 98° even in the evenings, while the swelling of the liver gradually disappeared, and the boy left the hospital perfectly well. Febrile temperatures in inherited syphilis, or even in late stages of acquired, have been so little studied that this case has much interest.

### Universal Alopecia.

W. J. Tyson relates three cases of this affection in healthy men; in all the change began in the scalp, and was attributed to some neurotic disturbance, viz.: In the first case, anxiety and trouble; in another, fright from a sudden thunder-storm; in the third, a fall on the head, which affected the functions of the brain. There was no restoration of hair in any case. In one the nails of the thumbs and great toes fell off simultaneously with the hair.

Tyson points out that these universal cases differ from ordinary cases of alopecia areata not only in their generality, but in the fact that recovery seldom or never takes place. He supposes the starting point to be a "neurotic cause." (*Clin. Soc. Trans.* Vol. XIX—p. 120.)

The Transactions of the Pathological Society of London, Vol. XXXVIII. contains several papers on syphilitic affections and diseases of the skin:

### Syphilis.

W. M. Ord describes a gumma of the ascending parietal convolution of the brain which gave rise to noteworthy symptoms during life.

Quarry Silcock and F. C. Turner describe specimens of syphilitic ulceration of trachea and bronchi, in adults, the result of acquired disease.

R. W. Parker reports a remarkable case of obliterative endotracheitis and endo-bronchitis from congenital syphilis in a boy fifteen years old. Tracheotomy had been performed some years before to relieve the obstruction to respiration, and had been left a tracheal fistula. A renewed operation to close the tracheal fistula was successful; but death took place from lung disease. The signs of general inherited constitutional syphilis were unmistakable.

A case of syphilitic hepatitis and interstitial pneumonia in an infant is reported by Charters Symonds, with two plates.

Another remarkable specimen was that of an old hydatid of the liver imbedded in a syphilitic growth. The hydatid cyst was about two inches in

diameter and the surrounding growth, regarded as syphilitic, was, therefore, very large, weighing about one hundred ounces. It had, however, some resemblance to lymphadenoma. The history of syphilis was very distinct.

On skin diseases the Pathological Transactions contain the following papers:

*Symmetrical Psoriasis* in a man who also suffered from rheumatic fever, by Stephen Paget.

Various specimens illustrating *Leprosy*, with short descriptions from Dr. Beavan Rake, of Trinidad.

*Granuloma fungoides*, a case described by J. F. Payne (with three plates). Payne denies the presence of micro-organisms in this disease, and explains those described by Hochsinger, and others, as being granules contained in cells. His account agrees very nearly with that of Köbner, though each was published independently.

*Pseudo-granuloma fungoides* is the name given by F. S. Eve to a growth on the foot of a man aged fifty-three, which subsequent record showed to be the outcome of a hereditary syphilitic taint.

Payne contributes also cases of "*erythrasma*," and "*a nodose condition of hairs*."

J. F. PAYNE.

LONDON.

## Book Review.

ON THE PATHOLOGY AND TREATMENT OF GONORRHOEA AND SPERMATORRHOEA. By J. L. Milton, M. D., Senior Surgeon to St. John's Hospital for Diseases of the Skin, London. New York: Wm. Wood & Co. 1887.

THE monographs of Milton, upon Gonorrhœa and Spermatorrhœa, have been long recognized as the most popular and valuable treatises upon those subjects in the language.

The New York publishers have done a good service to the profession in presenting these works in a single volume.

In noticing the Fifth edition of the "Pathology and Treatment of Gonorrhœa," in a previous number of this JOURNAL, we took occasion to say that "the book is admirably well written, the style clear and lucid, the reasoning forcible and philosophical, and the conclusions in the main logical and correct. The reader cannot fail to be impressed with the author's thorough familiarity with the subject, the fairness of his views, and the honesty of his convictions." A similar characterization would apply to the "Pathology and Treatment of Spermatorrhœa." While the views of various authorities are carefully collated and considered, the work is based largely upon the author's own observation and clinical experience.

PAPERS UPON GENITARY SURGERY. By A. T. Cabot, M. D., Surgeon at the Massachusetts General Hospital, etc. Boston: David Clapp & Son.

The mere enumeration of the titles will indicate the interesting character as well as the wide range of the subjects embraced under the above heading.

1. Nephrotomy for Hydronephrosis: Recovery.
2. The Constrictor Urethra Muscle: Its Relations to Urethral Pathology and Treatment.
3. Case of Multiple Calculi in the Bladder.

4. The Application of Antiseptic Principles to Genito-Urinary Surgery.
5. Notes on the Treatment of Stone in the Bladder : Report of thirty cases.
6. A Case of Supra-pubic Lithotomy.
7. A Case of Hysterecotomy for the Relief of Pyelitis from Obstruction.

## Selections.

### COMPLICATIONS OF GONORRHOEA.

IN a recent clinic Dr. Mauriac (*Journal de Med. et de Chir., Prat.*) called attention to a patient who suffered intensely from one of the phenomena altogether special to gonorrhœa, namely pain in the heel. In this particular case the pain had extended to the great toe. In some patients this pain becomes of extraordinary intensity; its exact location is difficult to determine, and it has not been definitely settled whether it results from a serous sac lesion or from a periostitis. Whichever it may be, it is very characteristic and its persistence often very remarkable. In this same patient at the time of a previous attack of gonorrhœa the pain lasted for two or three months and only disappeared under the influence of an intercurrent attack of typhoid fever. In fact, we often see an acute affection thus cause the disappearance of a chronic painful affection.

One of the remote complications of gonorrhœa consists in an induration of the cavernous bodies of the penis. A patient who had six months before had a gonorrhœa which three times had alternated between the acute and the chronic state and finally had appeared cured for two months, noticed that two spots had formed in the corpora cavernosa. One was larger than the other, somewhat painful during erection, and caused some deformity.

This form of sclerosis of the cavernous bodies constitute quite a serious condition, for it has always a tendency to increase rather than to disappear. Gonorrhœa, especially when it has been very intense and of long duration, is the principal cause of this affection, which has nothing in common with syphilis, as one might be tempted to suppose. It may, however, be met with in arthritism, in gout and in diabetes without the existence of a gonorrhœa. Another form of penile sclerosis is that which affects the glans, this is also produced by gonorrhœa and accompanies narrowness of the meatus, and also at times a fistula of the fossa navicularis.

### THE TREATMENT OF SURGICAL TUBERCULOSES.

SURGICAL tuberculosis are most frequently manifestations of a diathesis. The whole organism is infected before the appearance of local lesions. Surgical intervention can then only relieve the local affection.

Realizing that operation may cause severe accidents, we must endeavor to render it as innocent as possible, recollecting that we are in the presence of an enfeebled organism, in which operative traumatism will react with greater force.

The means of action which we have studied are only applicable to a restricted number of cases. They have the advantage over cutting instruments, that they protect against traumatic auto-inoculation.



The anti-parasitic properties of iodoform are much discussed at the present time, nevertheless its employment as an injection in ethereal solution has given numerous good results in the treatment of cold abscesses.

It is advantageous in the sense that it does not require a continual supervision of the patient.

The chloride of zinc is an excellent local destructive agent. Its employment as an intra-dermic injection appears applicable for the opening of cold abscesses in patients who cannot be kept under regular observation. It is impotent against bony lesions. Here the red-hot iron is indispensable. Acupuncture, or ignipuncture has given incontestable success in the treatment of white swellings, in the opening of small glandular abscesses, subcutaneous tubercular gummata which have not yet softened, abscesses of the thoracic walls which have developed in the external layers of the periosteum (Kléner and Poulet), and finally lead to a superficial and secondary osseous caries.

Finally, the surgical treatment will be so much the more successful the more we insist upon medical treatment. Good hygienic surroundings, good climate, salt baths, exercise in the open air, iron, arsenic, iodides, quinine, bitter tonics, cod liver oil in large dose, are all means of which a long experience has proven the utility.—(Dr. Martel. *Thèse de Paris*, 1887. *Bul. Gen. de Thèrap.*, Sept., 1887.)

### ON THE THERAPY OF GONORRHOEA.

DR. LEDETSCH (*Prager Med. Wschr.* No. 32, 1887) has during the past three years frequently employed injections of quinine in the treatment of gonorrhœa with results which in some cases may be termed brilliant.

Several chronic cases which for months had persisted in spite of all treatment, to the author's astonishment were cured in a few days. He employs the following injection:

R. Quinæ Bisulph.....	1.0
Glycerini.....	25.0
Aq. Destil.....	75.0

At first, three times daily, then twice, and later only once.

A slight burning sensation is alone complained of.

### INFLUENCE OF IODIDE OF POTASSIUM ON THE ELIMINATION OF MERCURY.

ACCORDING to the experience of many authors, and of Melseus in particular, the iodide of potassium is the best means of combatting the intoxication produced by the poisonous metals. The iodide of potassium has been experimentally employed by Dr. Souchow in persons subjected to a mercurial medication, and the following conclusions have been arrived at:

1. The elimination of mercury by the urine begins later, and the quantity of mercury eliminated is comparatively less in the cases in which iodide of potassium is simultaneously taken.

2. The iodide of potassium administered during or after the mercurial cure lessens at once the quantity of mercury daily eliminated.

3. Consequently, far from contributing to the elimination of mercury, as Hermann Melseus, Michel, and others have believed, it would appear to oppose elimination and to be of no utility in poisoning by mercury, as Melseus thought.—*Journal de Médecine*, Oct. 20, 1887.

### Books and Pamphlets Received.

- SURGICAL Disorders of the Urinary Organs**, by Reginald Harrison, M.D., 3d Edition; London. J. and A. Churchill, 1887. Notice in subsequent number.
- Lehrbuch der Haut u. Geschlechts Krankheiten** von Dr. Edmund Lesser. Erster Theil, Hautkrankheiten. Leipzig: Verlag von F. C. W. Vogel, 1887. Notice in subsequent number.
- Die Diagnose der Blasen und Nierkrankheiten mittelst der Harnleitespincette** von Dr. M. Tuchmann, Berlin, 1887.
- Ulcerationes Tuberculeuses de la Peau** par le Docteur Maurice Vallas, Paris, J. B. Baillière et Fils, 1887.
- Diseases of the Bladder and Urethra in Women**, by Alex. J. C. Skene, M.D., 2d Edition, New York: Wm. Wood & Co., 1887.
- De l'Electricité comme Agent Therapeutique en Gynecologie** par Dr. Paul F. Mundé, Traduit et annoté, par le Docteur P. Mènière, Paris, Octave Doin, 1887.
- Sur la Lèpre, Nature, Origines, Transmissibilité, Modes de Propagation et de Transmissibilité**, par M. Ernest Besnier, Paris: G. Masson, 1887.
- The Toxic Effects of Iodoform, Cutaneous and Systemic**, R. W. Taylor, M.D. (Reprint.)
- Classifications of Skin Diseases**, by Edward Bennett Bronson, M.D. (Reprint.)
- "Dermatitis Herpetiformis" (of Dubring) as a Distinct Disease**, by L. Duncan Bulkley, A.M., M.D. (Reprint.)
- Subcutaneous Division of Urethral Stricture**, by Claudius H. Mastin, M.D., LL.D. (Reprint.)
- Ulcers Resulting from Spontaneous Gangrene of the Skin during the Later Stages of Syphilis, and their Relation to Syphilis**, by Herman G. Klotz, M.D. (Reprint.)
- On the Advantages of a Compound Salicylated Plaster in Dermatological and Surgical Practice**, by Herman G. Klotz, M.D. (Reprint.)
- On Frost Itch, or Prurigo Hyemalis**, by J. F. Payne, M.D., F.R.C.P., London.
- Salt in Demal Hygiene and Therapeutics**, by Henry G. Piffard, M.D. (Reprint.)
- Introduction to the Study of the Influence of Diet in the Production and Treatment of Skin Disease**, by James C. White, M.D., Boston. (Reprint.)
- A Short Account of the Disease Called "Ainhum," with Report of Case**, by Francis J. Shepherd, M.D. (Reprint.)
- Sull Assorbimento del Mercurio Metallico par la Pelle** dal Prof. Prino Ferrari (Reprint.)
- The Management of Eczema Infantile**, by B. Merrill Ricketts, M.D., Cincinnati. (Reprint.)
- Iodism in the Nursing Infant**, by Henry Koplik, M.D., New York. (Reprint.)
- Experimental Study of the Effects of Puncture of the Heart in Cases of Chloroform Narcosis**, by A. B. Watson, A.M., M.D. (Reprint.)

JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

FEBRUARY, 1888.

No. 2.

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**Original Communications.**

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CUTANEOUS PHOTOGRAPHY MADE EASY.<sup>1</sup>

BY

HENRY G. PIFFARD, M.D.,

New York.

THE desirability of keeping a permanent pictorial record of important and interesting cases of cutaneous disease is fully appreciated by every working dermatologist; but thus far the difficulties in the way of giving this practical effect have been so great that comparatively few pictures have been taken except by those who have given the matter special attention.

The chief obstacle has been the difficulty of securing in the consulting-room a sufficient and a proper distribution of the light, making it necessary in most cases to take the patient to the operating rooms of the professional photographer. To this many patients object. Even when they consent, an hour's time is lost for each negative secured.

My purpose this evening is to bring to your notice a simple method, devised by myself, whereby these inconveniences may be reduced to the minimum. The method referred to relates to the illumination of the subject, and not to any special construction of the photographic apparatus.

<sup>1</sup> Read at the meeting of the New York Dermatological Society, Dec. 20, 1887.

In my own office if diffused sunlight be used on a bright day, an exposure of thirty to sixty seconds has often been necessary ; but with the new method equally good pictures may be taken in the night or in a darkened room in a fraction of a second. This is brought about by the use of an artificial light produced by the instantaneous combustion of magnesium powder. This gives a momentary flash of light of surprising brilliance and amply sufficient for the purpose.

Magnesium by itself will not ignite or burn as rapidly as when in contact with some more easily inflammable substance, and I find by experiment that ordinary photographer's pyroxylin, or gun-cotton, is admirably adapted to the purpose in view.

The magnesium and cotton are arranged for use in the following manner: A tuft of cotton weighing about seven or eight grains is spread out as a thin layer on any metallic surface, as a stone-lid or tin plate. Ten or twelve grains of magnesium powder is next sprinkled evenly over the cotton.

The patient is then brought into position and the focus obtained in the usual manner. If in the day time, daylight may be used for focussing, but if at night or in a darkened room, a candle or lamp held near the patient will answer as well.

The cotton-magnesium is now adjusted or held by the side of the camera and slightly in advance of the lens, care being taken not to bring it within the view angle of the lens. The plate holder is then affixed to the camera and the slide withdrawn. The room is then absolutely darkened, and the lens is uncapped. All being now ready, a lighted taper is applied to the cotton. This is followed by an instant flash which takes the picture. The lens is capped, the slide of the plate-holder is returned to its place, and the plate is ready for development, either by the operator if sufficiently skilled, or by a professional photographer, if desired.

Since my first publication of this instantaneous flash process, a large number of substitutes for the cotton magnesium combination have appeared. These are all in powder form and many of them contain chloride of potassium as an ingredient. Such mixtures are liable to premature and unexpected explosion and are not to be recommended when absolute safety is a desideratum.<sup>1</sup> Care, therefore, should be taken to obtain a mixture entirely free from this objectionable substance.

When a full-length figure is to be taken, in order to show the

<sup>1</sup> Since the above was written, an explosion, causing death, has resulted from one of these chloral of potash mixtures.

generalization of an eruption, I am in the habit of using the photogenic mixture in a pistol cartridge, and firing it from the weapon in the usual manner.

As regards the photographic apparatus available for office photography, I would strongly recommend for general use a rectilinear lens of eight to nine inches focus and a camera taking a 5 x 7 plate. The pictures that may be taken by the method here described are fully equal to those taken by daylight in a regular gallery, but in each case the excellence of the picture will depend in great measure on the quality of the lens and the skill displayed in the development of the plate. With the exception of development, all other manipulations may be learned in ten minutes from any practical photographer.

10 WEST 35TH STREET.

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#### HYPERIDROSIS—REPORT OF CASE, WITH REMARKS.<sup>1</sup>

BY

C. W. CUTLER, M.D.

MISS M. W., aged twenty-two years, presented herself for treatment at my office in January, 1887, with the following history: Parents both living and in good health. Has one brother also in good health, the family history being exceptionally good.

Until the age of thirteen years she had always been strong and healthy, but at that time just prior to her first menstruation she noticed that her hands were continually wet, as though just taken out of water—this condition making its appearance quite suddenly, without any loss of health. From that time to the present her hands have never been free from excessive perspiration.

Her general health has always remained good, although menstruation has never been regular; but whether present or absent, the condition of the hands has not changed. Within a week from the time that the disease was first noticed, the sweating reached its maximum, and since then, whether in winter or summer, it has continued unchanged.

The area of sweating has always been limited to the palmar surfaces of the hands and fingers, not appearing on the backs of the hands or above the wrists. The secretion has always been clear, perfectly odorless, and with a slight salty taste.

The quantity of the secretion varies but little from time to time, being nearly the same during the night or day, a little less

<sup>1</sup> Candidate's Thesis, read before the New York Dermatological Society.

when freely perspiring elsewhere, and slightly increased when excited, but, strange to say, only when pleasantly so.

I have had the case under close observation for six months, and find the history as given above verified in every particular.

I have examined the case carefully as regards its *cause*, the *physiological condition* of the parts affected, the *quantity* and *quality* of the secretion, and the *therapeutical agents* affecting it.

As to its cause I can find none unless it be nervous in origin. She is a strong, healthy girl, with all her organs in good condition and with no functional disturbance except that of the uterus.

She is, however, of extremely nervous temperament, easily excited and very quick tempered. Although slightly anæmic in appearance, she blushes readily even when spoken to, thus showing a lack of tone in the vaso-motor system.

Regarding the physiological condition of the affected parts, the sweating is found to be strictly limited to the palms of the hands and the palmar surfaces of the fingers; the backs of the hands and fingers being dry and normal. The affected parts are slightly cool to the touch, the skin thickened and sodden, but not wrinkled like that of a washer-woman. The circulation is good, the nails red and normal in appearance. Both tactile and painful impressions normal—being the same in both hands.

Through a magnifying glass the skin seems thickened, cedematous and more translucent than normal, the capillary blood-vessels dilated and the mouths of the sweat ducts widely open.

The quantity of the secretion is enormous. When the hands are held down with the fingers apart, drops of sweat will fall every second, forming pools of water on the floor. From one hand about  $\frac{3}{4}$  l of water can be obtained in five minutes. After wearing kid gloves for an hour, water can be wrung out of them, while the kid is soaked through. To prevent the water from ruining her dresses, she must constantly carry a handkerchief in each hand, and in an hour's time they are so saturated that water may be wrung from them.

At night her hands must be incased in towels to prevent the sheets from being wet through. With all this loss of water from the system, the thirst is but slightly increased or the urine diminished.

Chemically the secretion resembles ordinary perspiration.

As to treatment I have failed except in correcting the functional uterine disorder. Such agents as bismuth, tannic and salicylic acid, belladonna, atropia, ergot, tonics, etc., commonly employed in hyperidrosis, have in this case been utterly worthless to control the abnormal condition.

To-day the sweating of the hands was no more nor less than

when I first saw them, now some eight months ago, but still the young lady is willing to be further experimented upon.

The literature of excessive sweating is not very extensive. The disease is one of the so-called affections of the sudoriparous glands, and has received the names of hyperidrosis and ephidrosis. It may be divided into two grand divisions, *general* and *local* sweating.

*General Sweating* usually accompanies debilitating diseases as those resulting from septic infection, phthisis, malarial and other fevers, shock, heat, and the physiological effects of certain drugs. In most of these affections the result is probably due to a loss of tone in the vasomotor system.

In the sixteenth century a distinct disease made its appearance in Europe, which was called, from the excessive sweating accompanying it, *sudor anglicus*. This has since been considered as a form of malarial fever. With general sweating dermatologists have but little to do, but more especially with the more important and little understood *local sweating*.

The *causes* of local sweating are not known with certainty. That they are usually of nervous origin, I think most investigators will acknowledge, but as to exactly how this condition is produced, there is a wide range of opinion. Mr. Wheelhouse believes that there is situated in the brain one or more sweat nerve centres, and that sweating is the result of a paralysis of those centres by abnormal conditions of the blood. Dr. Myrtle, on the other hand, thinks that sweating is the result of paralysis of the terminal nerve filaments, which preside over the functions of the sweat glands.

To me it appears much more likely that sweating is caused by an affection of the sympathetic system of nerves, such as presides over the condition of the blood vessels. That there are sweat centres or ganglions situated at intervals throughout this system, and having direct control over a certain region of sweat glands, is very probable.

Drs. Eulenburg and Guttman have experimented in this direction, with some degree of success, in establishing this theory. To support this view, analogy, I think, will come to our assistance. We know that other secretions, as the lacrymal and salivary, are directly controlled by the sympathetic system of nerves through ganglionic centres, and that this is accompanied by an increase of temperature and vascularity in and about the glands.

In nearly all the cases of local sweating I have examined,

these physiological conditions are found to be present in a greater or less degree. Not infrequently we find the same nervous influence that calls forth an increased functional activity of some secreting organ will also produce local sweating. Two cases are reported by Parfianovitch and one by Rice in the *British Medical Journal* in which local sweating in the region of the parotid gland occurred only during mastication, when the salivary glands were most active.

In these cases, the same reflex nervous influence acting through the sympathetic system that called forth the flow of saliva also produced the hyperidrosis. We find the disorder so frequently accompanying some derangement of the nervous system, as nervous prostration, neuralgia, migrain, hemicrania, or some functional disturbance of an internal organ that its nervous origin or close connection with some disturbance of the nervous system can hardly be disputed. We all acknowledge the close relationship existing between that condition known as shock and extreme nervous prostration. One of the most marked symptoms of shock is sweating, and although it is most frequently general it is often localized.

As an example of this local sweating following shock, I am indebted to Dr. R. W. Taylor for the history of this most instructive and interesting case.

"The patient was a man aged thirty-two, thin and pale, who had suffered for years with chronic bronchitis and debility. He had never had any abnormal sweating. Upon a certain evening, about nine o'clock, he had an unpleasant encounter with the police, and became violently excited. I found him, about an hour later, bordering on collapse. A cold perspiration covered the body; pulse small and rapid, slow breathing. His hands and feet were extremely cold. The patient stated that after the fracas he became greatly exhausted, and among his other symptoms noticed that his legs and feet became the seat of profuse cold perspiration. At my direction his boots were removed, when it was found that his drawers and stockings were soaked with a watery fluid, and from the boots was poured a quantity, fully filling a large beer glass.

"This amount of sweat had been secreted in rather more than an hour. In a few days he regained his usual average of health."

I believe it to be as truly a nervous disease as chorea, and not a disease of the glands, for it is the exception rather than the rule to find any marked structural changes in the glands themselves.



Local sweating is prone to appear in certain regions of the body, and in the following order of frequency: soles of the feet, palms of the hands, axillæ, neck, groin, one-half the face and head, and half the body. Why it should occur in certain localities with the greatest frequency is probably for the same reason that gout makes its first appearance in the great toe. When it occurs on the extremities it is almost always symmetrically situated, but asymmetrically on the head, neck and trunk. This is probably due to the close relationship of the sympathetic ganglions sending nerves to the extremities, and the want of the connection between the ganglions of the head and neck.

Regarding the *pathology* of this disease little need be said. The affected sweat glands have been most carefully examined, and most frequently found without marked structural change, except such as would result from over-abundant secretion.

Dr. Latour, in his article published in 1873, speaks of the glands being a little larger than normal, their ducts dilated and the epithelium sometimes cloudy and swollen. But these changes are such as would result simply from the over-secretion. Had the ganglions of the sympathetic system supplying the region of these affected glands been examined, perhaps in them pathological changes might have been found, as have been reported in a few cases; but in most cases the disease is doubtless a functional one, and not accompanied by [recognizable structural changes.

The *symptoms* accompanying hyperidrosis are varied. When occurring on the head, neck, or trunk, it is usually associated with redness of the surface, a rise of surface temperature, and a dilatation of the blood vessels of the affected area. When it occurs on the extremities, a cold, clammy condition of the skin exists, having a reddish-blue or cyanotic appearance.

Although the appearance of the skin differs so markedly according to the location of the affection, the physiological condition of the parts is probably the same; the physical differences being due to the distance from the centre of circulation of the blood. Dilatation of the arterioles and capillaries is accompanied by a rise of temperature of the surface, while the evaporation of moisture from any surface lowers its temperature. The blood of the head and trunk is so much warmer than that of the extremities, that, while in the former, the evaporation from the surface is not sufficient to cool the skin below its normal temperature,

in the latter it is more than equal to do so, and a lower temperature results.

The cooling of the surface of the extremities causes, secondarily, a stagnation of blood in the smallest vessels, and a blue appearance of the skin so frequently seen. Artificial heat, applied to such a surface, will frequently result in producing the same physical signs usually seen in hyperidrosis of the head and trunk.

The macerated condition of the skin of the extremities, occurring especially about the feet, is due to the lowered vitality of the skin, diminished temperature, and especially to the retarded evaporation of the moisture, causing the skin to be continually water-soaked or surrounded by wet coverings. In four cases out of five pain and tenderness of the feet, not rheumatic, is due to the over sensitiveness of a constantly macerated skin, the result of local sweating.

Frequently, patients have presented themselves to me with these symptoms, not mentioning any undue sweating, which, upon investigation, have found to be cases of simple hyperidrosis, many of them yielding readily to treatment.

This macerated condition of the skin leads frequently to exfoliation of the epidermis, especially of the soles of the feet. Neuralgia, hyperæsthesia, anæsthesia, or more frequently subjective sensations, are not uncommon symptoms associated with hyperidrosis.

When these symptoms do exist, they are usually found in persons of a neurasthenic or hysterical tendency.

There may, or may not, be constitutional symptoms present in persons suffering from hyperidrosis localis. When they do exist they are usually of some functional nervous disorder associated with anæmia. Although I do not intend in this paper to treat of bromidrosis, it may be said that the bad odor in most cases of sweating is the result of uncleanness. Let me here quote from the writings of Dr. G. Thin :

“The mixture of sudoriparous and sebaceous secretions with the serum which exudes, affords a suitable pabulum for a species of bacterium, the bacterium foetidum, which grows and multiplies and is the source of the offensive odor so frequently encountered in such cases,—so offensive as sometimes to banish such persons altogether from society.”

If this so-called pabulum be removed from the affected parts as soon as secreted, the odor, sometimes so terrible, is not noticed. The *complications* of hyperidrosis are usually of an erythema-

tous or eczematous character, intertrigo perhaps being the most common. Sudamina and miliaria are not uncommonly present when the trunk is affected.

As to the *treatment* of local sweating, I have but little to say. Believing as I do in its nervous origin, constitutional treatment is usually indicated.

In the anæmic cases, iron and strychnine seem especially serviceable, and benefit almost always results from their use. Arsenic is also a valuable internal remedy.

In the local forms of sweating I have met with very poor results with drugs, which from their physiological action, would seem to be called for. Ergot, atropia, belladonna, gallic acid, digitalis, ergot, sulphuric acid and quinine have been but poor agents in my hands, the last two being the most successful.

Local treatment is always indicated; even if a cure is not effected, relief can usually be obtained.

The agents yielding the best results are the drying and astringent powders, but these, to act well, must be thoroughly rubbed into the affected skin and kept in constant contact.

Powders containing bismuth and salicylic acid have given me the best results. Astringent lotions of lead acetate, tannic acid, belladonna, acetic and sulphuric acids, have acted well in some cases if applied frequently. In affections of the feet, the stockings should also be wrung out of such solutions, and dried before wearing.

As to the use of ointments and plasters, nothing, I think, has been found to act better than the diachylon ointment as employed and recommended by Hebra. This treatment is especially beneficial in the severer forms of excessive sweating of the feet.

If you ask me why local application should cure a constitutional nervous affection, let me ask you why the local treatment of diphtheria is of such vital importance in the management of that severe general disease?

In treating the local manifestation of a constitutional disorder, we, not only mechanically relieve the local symptoms, but by placing the affected parts into as nearly a normal condition as possible, we just so far come to the aid of nature in establishing a cure.

In conclusion, let me recapitulate some of the thoughts expressed in this paper.

1. That the cause of hyperidrosis is usually a nervous one.

2. That the secretion of the sweat glands seem to be controlled by the sympathetic ganglions or system of nerves.

3. That hyperidrosis is a functional affection of the sympathetic system.

4. That the sweating of the extremities is usually symmetrical, owing to the close relationship and anastomosis of the sympathetic ganglions of the trunk ; and asymmetrical on the head and neck for want of this relationship.

5. That as there is but slight structural change in the affected sweat glands and that is accounted for by the hyper-secretion, the disease is probably functional and not organic.

6. That the difference in appearance of the affected skin on the extremities and trunk is due to the distance from the center of circulation, as the physiological conditions are the same.

7. That painful and tender feet, not rheumatic, are usually the result of hyperidrosis.

8. That bromidrosis is usually the result of uncleanness—not removing the secretion promptly.

9. That nerve tonics are usually indicated in the treatment of hyperidrosis.

10. That local treatment is always indicated, and although it may not effect a cure, it nearly always relieves the symptoms.

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## ON THE CLINICAL DIAGNOSIS OF LUPUS ERYTHEMATOSUS OF THE HAND AND FOOT. <sup>1</sup>

BY

HERMANN G. KLOTZ, M.D.,

Attending Physician, German Hospital and Dispensary, of New York.

THE following two cases of lupoid disease of the hand and foot, which have been under my continued observation within the last three years, have attracted my attention in a very high degree. Their peculiarities seem to justify the desire, not only to bring them to the knowledge of the profession, but also to consider more minutely those features which principally enter into the establishment of their diagnosis. The restriction of such an investigation to the clinical symptoms, will not, I believe, render it valueless, considering that in the diagnosis of hardly any other class of skin diseases have we to

<sup>1</sup> Candidate's Thesis presented to the New York Dermatological Society.

depend more on clinical observation and on clinical experience, than of those which histologically, according to Virchow and Auspitz, constitute the group of the *granulomata* of the skin.

Case I.—Charles D——, fifty years of age, born in Germany, eighteen years a resident of the United States, a cap-maker by trade, applied for treatment at the German Dispensary, February 21, 1885, giving the following history :

The patient, who is married, has always enjoyed good health excepting transient affections of the stomach ; he has led a regular life, using beer and tobacco moderately ; never had syphilis or other venereal diseases. Over twenty years ago a small reddish wart-like prominence, of the size of a split pea, made its appearance on the distal phalanx of the right middle finger, causing no sensation except a slight stinging pain. Part of the patient's occupation is to fit heavy caps tightly over wooden blocks, drawing them down by the finger tips. To this work he attributed the origin of the affection. Cauterization with nitrate of silver rather irritated the affected part and soon caused the disease to spread, in the shape of a red elevated patch, along the dorsal aspect of the finger, as far as the proximal phalanx, approaching the back of the hand about nine years ago. Cauterization with some acid (the patient speaks of muriatic acid) always seemed to aggravate the disease. After a long period of comparative rest or very slow progress, about one and one-half years ago, the affection began to spread with greater rapidity over the back of the hand, and over the lateral aspects of the middle finger until it reached its present extent. At the same time the distal phalanx, which during the period of slow progress along the finger had nearly healed entirely, began to again assume its former appearance. At no time was a discharge or moisture noticed ; the patient was able to attend to his work, not without, however, some pain and inconvenience at times.

On examination the disease was found to be limited to a single distinctly circumscribed, movable patch on the right hand. This patch extended from the nail of the middle finger over the entire dorsal aspect of all three phalanges and over both lateral aspects of the two proximal phalanges about half-way to the palmar surface, and on reaching the back of the metacarpophalangeal joint, widened into a nearly circular elevation, somewhat larger than a silver dollar. Its outlines on the finger were distinctly defined by a small infiltrated border of a dull red color, about two millimetres high, which, on extending to the back of the hand, took the shape of a firm, sloping wall, nearly one centimetre wide and about eight millimetres high. This circumvallation showed a smooth, in some parts glossy surface of a dull red color, which on the border changed into a more bright red tint. On pressure, the brighter color disappeared

easily, to return immediately after the removal of the pressure; but the more central zone, which gave the impression of considerable firmness and resistance, changed its color more sluggishly, assuming a brownish or yellowish tinge, like the horny infiltration of tylosis. The surface of the wall was devoid of hair and no outlets of sebaceous glands were visible. Towards the healthy surrounding skin there was no abrupt elevation, the outline being defined only by the narrow, ribbon-like, bright red zone, while towards the centre of the elevated patch the horny edges were slightly inverted. This central plateau, of about the size of a silver half-dollar, presented an even, smooth surface, covered throughout by a thin, dry, hard and firmly adherent, dark gray and dirty green, scaly crust; no moisture of any kind was visible, nor could any be produced by pressure. Towards the proximal phalanx the scaly crust became thinner and of a more whitish color, and nearly disappeared over the phalanx itself, showing a thin, depressed, whitish scar, surrounded by a small scaly ridge and the red border mentioned before. The second phalanx again was found to be covered with hard grayish scales, divided by transverse fissures into several parts. The distal phalanx was free from scales, and presented an uneven, wart-like surface, on which numerous small, horny papillæ, about one to two millimetres high, some pointed, some blunt, could easily be distinguished, particularly about the nail, around which they formed an abrupt edge, about four millimetres high. The nail itself was left intact in its proximal portions, while its outer edge was raised and slightly everted by the thickening of the hypertrophied horny matrix. This condition of the nail, however, seemed to be due to its exposure during work, which may also account for the absence of the scales from the last phalanx. The finger and the hand could be brought into flexion without difficulty.

The horny crust could not immediately be removed, but after the continuous application for several days of a 5% salicylated soap plaster, it was softened, and loosened sufficiently to allow of inspection of the diseased patch itself. This appeared uneven, formed by numerous papillary growths of different size and shape, some being pointed, some blunt, others club-shaped, more or less closely approximated, with fissures between them. From the inferior aspect of the crusts, tag-like processes were seen to project, which filled up the interstices between the papillæ. The papillæ themselves exhibited a perfectly dry surface, covered with epidermis of various thickness; no secretion of a watery discharge nor of pus could be pressed out of the depth of the fissures.

The patient was advised to keep the whole patch constantly covered with the 5%, later on with the 10% compound salicylated plaster<sup>1</sup> spread on muslin, and was given arsenic internally.

Under this simple treatment, which did not prevent the patient from attending to his work even for a single day, the papillary growths soon began to flatten down and after several months had nearly disappeared, only shallow impressions of the now smooth surface indicating the seat of the previously observed deep fissures over the back of the hand. The whole patch gradually showed diminished infiltration, and after about one year presented a continuous smooth surface of a slightly dull red color, except over the first phalanx, where the thin whitish scar had not changed much in appearance. The skin was but very little thickened, yet very firm, inelastic and stiff, owing apparently more to hypertrophy of the horny layers of the epidermis than to infiltration of the cutis itself, showing but indistinctly the network of lines generally found on the healthy skin. When I saw the patient for the last time, in February, 1886, the affected part exhibited a color but slightly deviating from the normal, being of a bluish tint, and the skin had nearly attained its former elasticity; the patient, however, had had an attack of hemorrhage from the lung. When I tried of late to hunt up the patient, to ascertain the present condition of his hand, I was informed that about a year ago he died of consumption at one of the hospitals of this city.

Case II.—Henry E——, eighteen years of age, born in the United States, of German parents, a tailor by trade, was first seen at the German Dispensary on November 10, 1885. He appeared to be rather small for his age, presented deformities resulting from kyphosis of the dorsal region of the spinal column; he was poorly developed and poorly nourished, of a pale, sallow complexion with dark brown hair. From the patient himself—a not very reliable source—and from his father, a healthy, well-developed and intelligent man, the following history was obtained: The boy was always of a weak constitution and in his second year developed signs of spinal disease, probably with fever, which apparently healed toward the end of the second year, not, however, without deformity. Although at no time very strong or in full health, the patient has not suffered from any particular disease since; there is no history of syphilitic infection, nor can any of those conditions of the teeth, eyes, ears, etc., be discovered, which generally are ascribed to syphilis hereditaria tarda. Soon after the spinal trouble subsided, the present disease of the skin began to develop, first on the left foot, and soon after on the left thigh, and ever since has gradually spread to its present dimensions. The affection has caused but very little inconvenience or pain, no weeping or suppuration was ever observed.

On examination, the left foot was found to be the seat of a very extensive patch of disease. Its outline, beginning in the middle of the dorsal aspect over the tarso-metatarsal joints, extended along the outer side of the foot in irregular

lines, being distant about five centimetres from the sole anteriorly and somewhat less than three centimetres near the heel. Here it curved upwards and forwards, around and above the malleolus externus, until it passed the crest of the tibia about nine centimetres (three and one-half inches) above the starting point. From here it extended to the inner aspect of the foot, taking a similar course above the malleolus internus towards the heel, not as closely approaching it, however, as on the outside, and then extended downwards again in a nearly straight line to the middle of the foot, at a distance of about two and one-half centimetres from the sole. The greatest distance from one side to the other, in a line drawn over both malleoli, was twenty-one centimetres (eight inches). The shape of the whole patch was irregularly semilunar, and its area reached the size of a medium-sized hand. Its outlines were sharply defined around the entire circumference by the irregular curves of a distinct erythematous band of a bright red color, a few millimetres wide, which was scarcely raised above the niveau of the surrounding healthy skin. This zone was smooth, devoid of hair, yet more or less distinctly showing the natural ridges and depressions; the red color disappeared fully under pressure, to return immediately afterwards. Within this red band a second zone could be distinguished, gradually rising to a height of five to eight millimetres, from one to one and one-half centimetres wide, of a smooth, partly glossy surface, free of scales, crusts or pustules. It was of a livid red color, which under pressure disappeared but slowly, leaving a yellowish tint and giving the impression of a solid infiltration of the lower strata of the cutis and of a thickening of the horny layer of the epidermis. This wall-like elevation rose to its greatest height on the outside of the foot, over and around the malleolus, where the extreme portion of the patch ended rather abruptly into a nearly circular, flat-topped knoll.

Beyond the slightly inverted edges of this second zone, the surface of the patch was covered by a mass of hard, dry scales of a dark greenish and brownish color, which were firmly attached to the underlying tissue, and, on trying to remove them, were found projecting numerous processes into the latter. The surface was broken in different directions by fissures of various depth. No moisture of any kind was found either on the surface or directly underneath the crusts, nor could any be produced by squeezing the patch.

After several days of continuous application of the five per cent. compound salicylated plaster, at the next visit of the patient, the dry, hard crusts were found to be almost completely removed. The surface of the entire central portion of the patch, including the circular elevation over the malleolus externus, was found to be irregular and uneven, owing to the presence of nu-



merous hard, dry, papillary growths of various shape, some being rounded, some pointed, some club-shaped, increasing in length towards the centre, where the papillæ in themselves reached the length of one centimetre and over, and formed several parallel ridges. Between the papillæ, clefts or fissures of various depth were found to exist, which had been filled up by the horny masses which projected downwards from the crust, as could be distinctly seen on such places where the scales had not been entirely removed, but loosened enough to be drawn off in their totality. Even then no moisture of any kind could be found, neither spontaneously nor after squeezing and pressing.

A second infiltrated patch of irregular shape was found on the interior and posterior aspect of the left thigh, directly below the gluteal fold and the scroto-femoral angle. Beginning with a width of about four centimetres in the back, it extended for about nine centimetres forwards, towards the scrotum, narrowing gradually, and ending with a width of about two and one-half centimetres in the plica scroto-femoralis. It was surrounded by a slightly raised, smooth border of a bluish red, livid color, about five millimetres wide, everywhere sharply defined, bearing no scales or crusts, while the central portion, rising to a height of about four millimetres, bore a layer of dry, yellowish, somewhat brittle scales; after the removal of which the same uneven surface was found, formed by numerous hard papillæ, however, of much smaller dimensions than those described on the foot of the patient. There was no moisture of any kind under the scaly crust, nor between the papillæ; no itching or other sensation except occasionally slight burning in either patch.

The patient was ordered to keep the diseased parts constantly covered with the compound salicylated plaster, spread on muslin; at first the five per cent., later the ten per cent. plaster was used. From the first of December, 1885, he was given arsenic and iron. At the second visit the patient complained of a very itchy, disseminated, papular and pustular eruption, with which several members of his family were simultaneously affected. It proved to be the scabies and was readily cured. In February, 1886, a rheumatic affection of several joints made its appearance, which early in March terminated into a peculiar swelling of the dorsal aspect of both wrists. About the same time an ulcer of the size of a silver quarter was noticed on the left leg, several inches above the infiltrated patch, with yellow floor and abrupt edges, and a week later several itchy pustules in the same locality. The latter seemed to be the outcome of a relapse of scabies, being easily relieved by applications of bals. peru.; the ulcer, however, undoubtedly looked suspicious of syphilis. In regard to the continued swelling of the wrists, iodide of potassium was given for several weeks, when the ulcer healed, leaving a thin,

even scar, and the affection of the joints had entirely disappeared. The original patches were not visibly affected by the iodide, therefore the former treatment was again resorted to: arsenic internally, and the compound salicylated plaster locally. This has been continued very regularly ever since, interrupted only by the application of a one per cent. solution of bichloride of mercury in tincture of benzoin, as recommended by Dr. R. W. Taylor.<sup>1</sup> As soon as these applications began to irritate the surface, which generally took place after two or three weeks, they were replaced again by the plaster. Decided improvement was soon noticed, the patches did not show any tendency to spread farther, no new formation of crusts took place, the papillary growths flattened down, and the infiltration of the border as well as of the central portion became greatly diminished. The patient, satisfied with the steady progress in healing, and being but little inconvenienced by the disease during continued work, has repeatedly refused to avail himself of the opportunity to enter the German Hospital, in order to have the cure of his disease somewhat accelerated by surgical procedures, partial destruction of the exuberant papillæ and border by means of the thermocautery being intended.

At present he presents the following condition: In looking on the left foot from a certain distance, the patch still exhibits its original dimensions distinctly defined by a bluish tint of the skin, which on close inspection is by no means as striking. But a very slight elevation remains, the surface is smooth, except in several circumscribed places, the skin is firm, resistant and somewhat less pliable, apparently owing to the great development of the horny layer of the epidermis more than to the infiltration of the cutis itself. It is quite probable that scales would be found as soon as the plaster was left off for any longer period. In the middle of the dorsum near the lower limit of the patch, and near the upper margin on both sides, about an inch from the latter, there remain three not sharply defined patches, each about the size of a quarter, where the papillary formation can still be seen to a slight degree. These patches are constantly growing smaller and flatter and probably will soon entirely disappear. The greatest resistance to the treatment has been experienced from the extreme portion of the circular knoll over and around the malleolus externus, which still forms an irregular, biscuit-shaped prominence several millimetres high, in the centre of which several papillary growths can still be seen, while probably in consequence of the pressure of the stiff heel of the shoe, the smooth wall has been flattened down into a thin, sharp edge, which somewhat overlaps the surrounding skin.

The patch on the thigh, to which the patient has not atten-

<sup>1</sup> Journal of Cut. and Ven. Dis. I., page 42.

ded quite as regularly as to the lower one, has likewise been greatly reduced. It still shows a livid red, slightly elevated border, but of reduced width; the surface is even and smooth, covered by thin, whitish scales, with a whitish surface underneath, showing, on several spots, dots of a darker red shade. The portion close to the scrotum has been transformed into a uniform, smooth, elastic scar of a light bluish color, entirely pliable and free of scales. The tendency towards healing has been particularly pronounced within the last few months, and I expect to see the affection completely cured within several months. The general health and appearance of the patient have been very satisfactory of late.

When confronted with the first of these cases, I confess I was somewhat at a loss for a diagnosis; the close relations of the disease to lupus were sufficiently manifest, but several of its features, mainly the papillary growths, certainly rendered it doubtful among which of the varieties of lupus it should be classed. On perusing the literature, a paper communicated by F. N. Hyde, of Chicago, to the American Dermatological Association in 1884,<sup>1</sup> attracted my attention and seemed to afford a solution of the question. Hyde, in giving a very exact description of four cases of lupus erythematosus of the hand, apparently does not entertain the slightest doubt as to the correctness of his diagnosis; at least he has not made any efforts to establish the same or to give his reasons for adopting it. Several reporters and critics of his paper, however, have drawn the diagnosis into question, while others have accepted the same. Kopp, in the *Centralblatt für Chirurgie*,<sup>2</sup> says: "The circumstance, that the efflorescences made their appearance at first on the hands, might possibly raise some doubts about the correctness of the diagnosis, but the truly objective manner in which the description of the cases has been given by Hyde, hardly admits of a different interpretation." A French critic, however, signing L. B. (Brocq ?),<sup>3</sup> greatly regrets the omission by Hyde of the question of diagnosis. "It was indispensable," he says, "in the face of so unusual a course and localization of lupus erythematosus, to establish with precision the characteristic features which allow of a distinct differentiation from the superficial, serpiginous tertiary syphilides, from inveterate eczemas, from psoriasis of long duration, and particularly from the lupus sclerosus of Vidal." In fact, L. B. believes, to recognize in

<sup>1</sup> Journal Cutan. and Vener. Dis., 1884, II., p. 321, seq.

<sup>2</sup> 1885, page 893.

<sup>3</sup> Annales de Dermatol. Vol. 10, p. 611.

Hyde's cases the salient clinical symptoms of lupus sclerosus, and therefore cannot suppress his doubts about the correctness of the diagnosis. With this opinion Falkson in<sup>1</sup> *Monatsh. f. prakt. Dermatol.*, in a synopsis of the French periodical, seems to agree, while, in an editorial note, Unna acknowledges to have actually under treatment a case of lupus erythematosus of both hands, without an affection of the face. By adding the following remark: "The disease, moreover, is of much more frequent occurrence in England and America than on the European continent," Unna seems to side with Hyde. Recently O. Rosenthal, of Berlin,<sup>2</sup> in publishing a case of lupus erythematosus of the hand, has taken up the defense of Hyde, avowedly against the reproaches of L. B., and has carefully considered the points of the differential diagnosis of his case.

In trying to show that my cases also have to be classified as lupus erythematosus, I shall follow Rosenthal's example. Before doing so, however, it seems necessary to briefly consider the present state of the question on the nature of lupus erythematosus and its relation to lupus vulgaris and its different species.

In spite of its ventilation at the International Congress of London, in 1881, this question is by no means settled. Some authors (Kaposi, Neisser, Payne) claim that lupus erythematosus is either entirely, or at least in its commencement, a purely inflammatory disease, and in Ziemmsen's *Lehrbuch* it is reservedly treated as a superficial dermatitis next to eczema and impetigo by Veiel. Others maintain that lupus erythematosus is really a milder, more superficial form of lupus vulgaris or essentialis (*Lupus qui détruit en surface*), among them Vidal, the late Auspitz, and others, while others again do not take so decided a position, but, as is done in the greater number of hand and text-books, acknowledge the close relationship of both types by placing them next to each other. Besides, the conviction is met with, among others with Famieson, that cases occur which make a complete transition from one type to the other, and bridge over the interval between lupus erythematosus and the more superficial and non-ulcerative forms of lupus vulgaris. The difficulty becomes still greater by the differentiation made by several authors of lupus erythematosus of the German and French and that of British authors, which, however, may simultaneously occur on the same individual.

<sup>1</sup> 1885, V. p. 47.

<sup>2</sup> *Deutsche Med. Wochenschrift*, 1887, No. 19, p. 411. *Verhandlungen des and Vereins für Innere Medicin.*

Naturally, a solution of this question was expected from microscopical investigation, but what Auspitz stated already in 1864,<sup>1</sup> namely, that the anatomical process is more or less identical in every species of granuloma, he still maintained in 1881,<sup>2</sup> and still later with but slight modifications in 1883.<sup>3</sup> At the former place he says: "Since 1864 the histological examination of these new growths has undoubtedly made some progress, but has not as yet succeeded in establishing a decisive anatomical difference between the single species of granuloma." The demonstration of the bacilli of tuberculosis in lupus vulgaris promised to become decisive, but still the dispute is going on and cannot be considered as definitely settled. So, but recently E. V. Meyer, writing under the auspices of Arnold and Czerny, of Heidelberg,<sup>4</sup> after reviewing the different opinions on the tuberculous nature of lupus, concludes as follows: "After all, in spite of numerous investigations, there has not yet been established a final, decisive argument, to precisely discriminate microscopically between lupus and other tuberculous affections of the skin, and we have often to rely on the macroscopical and clinical aspect. In spite of the minute descriptions of the microscopical appearance of the nodules of lupus, we nowhere meet with fully decisive criteria for an anatomical diagnosis." Conceded that in indisputable cases of lupus erythematosus the bacillus of tuberculosis has not thus far been found, even that is not a positive proof that it is not present there, and that it may not be found in the future. Did it not take years to demonstrate its presence in lupus vulgaris, even after, on the strength of clinical experience, the close relations between tuberculosis and lupus had been pointed out by several careful observers? and do not all microscopists agree on the scarcity of the bacilli even in the most characteristic cases? That these bacilli are present in doubtful cases, which by one dermatologist may be classified as lupus vulgaris, by another as lupus erythematosus, seems more than probable from the observations of Riehl and Paltauf,<sup>5</sup> to which I shall more fully refer later on. For the present, I believe the absence of the bacillus of tuberculosis cannot be accepted as an adequate reason to dissociate lupus erythematosus so widely from lupus vulgaris as has been attempted. It cannot be denied, that the

<sup>1</sup> Medic. Jahrbuecher, 1864.

<sup>2</sup> System of Hautkrankheiten, p. 167.

<sup>3</sup> Ziemmsen, Hautkrankheiten, I., p. 215.

<sup>4</sup> Virchow's Archiv, 108, 3, p. 383. Ueber Onychia Maligna.

<sup>5</sup> Vierteljahrsohrift, f, Dermatol, 1886, p, 19, seq.

characteristic process of the granuloma is present in both forms: the exuberant proliferation of small, embryonal cells, principally around and along the blood-vessels. It is true, that under certain circumstances, as has been shown by Auspitz,<sup>1</sup> the changes of this process may so closely resemble inflammatory changes that it is impossible to distinguish between inflammation and granuloma; but such conditions are not peculiar to lupus alone, but they are met with frequently in syphilis, tuberculosis proper and scrophulosis. Still nobody will think of separating the acute affections of the skin in syphilis from the chronic infiltrations due to the same cause and assign them to dermatitis superficialis.

To return to the diagnosis of my cases. I shall endeavor to show that they exhibit nearly all those clinical features which are almost unanimously considered essential to lupus erythematosus by the authors of hand and text-books. In examining them one after the other, I shall follow Duhring. It must not be overlooked that both cases came under my observation after the disease had existed for a long period, and that neither showed the slightest tendency to advance after treatment had been instituted. It was, therefore, impossible to study the earlier stages of their development, which indeed, as a rule, much more readily permit of the recognition of the more characteristic symptoms.

In both of my cases there existed circumscribed patches, showing distinctly defined marginal outlines. Their shape was in the whole irregular, but on several localities exhibited a decided tendency to assume a round, nearly circular form. Their color was of a dull red, their surface covered with hard, coherent, scaly crusts, which were firmly adherent and projected in the shape of processes, into interstices of the underlying tissue, although I do not mean to claim these openings as the outlets of sebaceous glands. The margins were evidently the most recently developed portions, demonstrating the tendency of the patches to peripheral extension; their border was well defined; the central portions, however, which as a rule appear depressed, did not show this condition, except in the first case on the back of the proximal phalanx of the affected finger, but were rather of higher elevation than the border. There was never any moisture or discharge in connection with the affection during its entire course, and in Case I. the nail remained perfectly free from the disease; the subjective symptoms were not prominent in

<sup>1</sup> System, p. 165.

either case and confined to moderate burning or itching. The patches apparently had remained stationary for some time; the course in both cases was decidedly chronic, the disease having lasted over twenty years in the first and sixteen years in the second case, longer than in any of the cases enumerated in Hyde's table.<sup>1</sup> In Case I. the history records distinctly the occurrence of several attacks at longer intervals, with periods of comparative inactivity, but in Case II. nothing definite could be ascertained of such an occurrence, although in the face of the long duration and the comparative small evolution, the same seems more than probable. The seat of the disease was not so an unusual one in the first case, as will be seen from Hyde's table, where thirty-five cases of lupus erythematosus of the hands are enumerated; in five, the hands only were affected, in twenty, the hands and fingers were the parts first affected. To Hyde's table the cases of Rosenthal and Unna, mentioned before, may be added, which are of so much more importance, as they modify the remark of Hyde, that no German author seems to have put on record a history of lupus erythematosus limited to one hand, as in England and America. As to the second case, it must be conceded that the seat is somewhat unusual indeed, particularly of the patch on the thigh. The foot is not mentioned either by Hyde or any other authors, only Erasmus Wilson<sup>2</sup> mentions the toes as affected with lupus erythematosus; but as he enumerates fingers and toes conjointly, it cannot be learned how often the toes were affected. Duhring, however, states, that while the disease shows a decided predilection for the face, ear and several other localities, it is really not limited to certain parts of the body; therefore, there is no reason to exclude lupus erythematosus, in this case, on account of the seat of affection. Both patients were of the male sex, which certainly furnishes a smaller percentage of cases than the female, one-third being generally considered the proportion in which the male sex participates. As to the age at which the disease commenced, the first patient dates back its origin to the age of twenty-eight years, which is strictly in accordance with common experience; the second case, however, in which the disease appeared soon after the completion of the second year, is unusual and nearly exceptional in regard to the point of age, although indisputable observations have been reported of the development of lupus erythematosus before puberty,

<sup>1</sup> l. c., p. 333.

<sup>2</sup> Journal of Cutan. Medicine, etc., II.

and even in children under ten years of age, as for instance, one case in Hyde's table at seven years, a second one where it was observed first at twelve, and two of Hyde's own observations, where it began at fourteen. It can be claimed, therefore, that my cases exhibit all the principal features of lupus erythematosus in accordance with Duhring's description, except the condition of the central portions of the patches; the depression and cicatrization generally found there being absent, except on one limited locality, and on the contrary, the centres showing a higher elevation than the borders. The discrepancy appears even greater, if the condition of the elevated surface is considered, as seen after the removal of the scaly crusts. The question is, whether such a condition is compatible with the nature of lupus erythematosus, and how it can be explained. In Hyde's first case the central depression is only partial, and in the third one it is limited to several central spaces, beyond which the patch was uniformly firm, infiltrated and covered with coarse yellowish scales. Hyde is reticent about the appearance in his cases of the surface of the patches after removal of the coherent scales, which are mentioned in all except the second case. In the first instance he says: "Over the affected phalanx of the thumb a singular effect was produced by the natural furrows of the skin, in consequence of which the disease in this locality was made to suggest to the eye the external configuration of ichthyosis simplex. This was due to a packing together of the adherent scales, and to the motions of the thumb, by which the skin was extended in the line of these furrows." And in Case IV. he speaks of "superficial fissures, lying transversely to the long axis of the digits, which showed a slightly reddened floor in each furrow. They were neither deep nor the apparent source of discharge," but they were certainly not the outlets of sebaceous glands. Case IV. is the only one of Hyde's occurring in a male "actively engaged in the pursuits of his business, that of a merchant, largely confined to his desk," therefore not enforcing arduous work of the hands. "It is possible," says Hyde, "that the hand was, as a consequence, subjected, more than those of women similarly affected, to the action of friction and external irritation of various kind." Similar influences, but undoubtedly in a much higher degree, and in a more aggravated manner, came into play in my cases. The hand of a cap-maker, who often has to strap tight-fitting caps over heavy wooden blocks, is evidently subjected to very rough handling, owing not only to the energetic contractions of



fingers and hand and the cracking of the surface therefrom, but also to the direct rubbing against the caps and the blocks. In Case II. we find the affection seated on the skin over the back of the foot, near and over the ankle-joint, where it is contracted and extended by the movements of every single step, besides being exposed to the constant pressure of the shoe. The second patch, however, on the thigh, is in constant contact with either the scrotum or the rough seams of the patient's under-clothing, exposed to constant friction in walking and in sitting; the crusts are liable, therefore, again to be torn off after each renewal. In both these localities a certain accumulation of filth may be safely assumed as a further element of irritation. Besides, the condition of the skin, varying on the different localities of the body in the normal state, has to be considered, that of the hand, foot and thigh being without doubt more coarse and tough, showing more distinct ridges and fewer sebaceous glands than that of the face. Still on the tender skin of the face most observations on lupus erythematosus are made and descriptions of the same given. A recent patch of lupus erythematosus will probably not differ much in any of the more exposed localities from those on the face; it will show a cover of thin scales, from which little tag-like processes project into the sebaceous glands; after their removal fine apertures will become visible, giving the well-known appearance as if the skin had been pricked with a coarse needle. These scales or crusts, called sebaceous-looking by Duhring, resemble very much those of *seborrhœa sicca*. How far such dry scales have to be taken for products of the sebaceous glands, and how far an overproduction of the horny cells of the epidermis really takes place, has been but recently called into question by Unna.<sup>1</sup> That exuberant proliferations of the epidermis may occur occasionally in connection with all the species of *granuloma*, has been mentioned by Auspitz.<sup>2</sup> It seems possible, therefore, that the scales of lupus erythematosus may be due more to the accumulation of horny cells of the epidermis than to an overproduction of the sebaceous glands, and that their projecting processes result from the proliferation of the interpapillary layer of the epidermis. But whatever their origin, situated over a joint, the scales or crusts will be extended by every flexion or extension of the joint; being inelastic, they will not bend, but crack, and will be gradually

<sup>1</sup> Monatshefte f. prakt. Dermatol., 1887, Nos. 15, 16: Was wissen wir von der Seborrhœe?

<sup>2</sup> System p. 165.

divided by transverse fissures in the natural grooves of the skin. These will multiply and deepen and widen with successive and often-repeated motions of the joint; the crusts themselves will be torn off occasionally, exposing the surface of the papillary layer, and, relieving it from the pressure of the epidermis, will allow the single papillæ to grow and to assume different shape and size upon their exposed extremity. This will finally terminate in exactly such a condition of the surface of the patches as found in my cases. As soon as the salicylic plaster was applied, the effect of which is partly to supply the mechanical pressure on the papillæ, which in the normal state is exerted by the horny part of the epidermis, the exuberant papillæ began to flatten down and gradually disappeared. Of course part of this effect is due to the action of the salicylic acid, which, hastening the removal of the crusts and the formation of a new and healthy epidermis, manifests itself in the smooth, strong surface, which the patches presented after the continuous application of the plaster. Indeed, I have no doubt that if the plaster had been omitted for some time, the patches would have soon been found covered with thin, whitish, dry scales, as is usually seen in the older portions of the patches of lupus erythematosus. In fact, the patch on the thigh recently presented exactly this condition as has been described already, and so came much nearer to the usual appearance of lupus erythematosus. The same observation would be made in case I., whenever the patient neglected his finger for some time. That the patches in Case II. present so smooth a surface and hardly any signs of a scar, I believe, is not a natural termination of the disease, but a consequence of the mild treatment, and will be observed on other localities whenever a similar treatment is followed. The abstinence from surgical interference and from the application of strong caustics has prevented any real loss of substance, the infiltration of the tissues has been reduced, but gradually, and has given way to that peculiar atrophic condition which characterizes the final stage of lupus erythematosus, while in Case I. we find visible scars on the first phalanx, where strong caustics had been once applied. It seems, therefore, that the peculiar condition of the central portions of the patches in my cases is not irreconcilable with the pathology of lupus erythematosus, even if another much more simple explanation is not considered acceptable, namely: to assume an individual disposition for papillary hypertrophy, either permanent or temporary, the same disposition which we know thus far as the

only cause for the formation of the common warts. There is no reason, therefore, why the diagnosis of lupus erythematosus should not be maintained in both my cases, if it can be shown why they cannot very well be ranged with any other disease of a similar appearance.

*(To be continued.)*

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## Society Transactions.

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### THE NEW YORK DERMATOLOGICAL SOCIETY.

#### THE 177TH MEETING.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. BRONSON presented a case of

#### PECULIAR ERUPTION ON THE NOSE

for diagnosis.

The patient was a man about thirty-five years of age. He gave no history of syphilis. He had been married about ten years and had reared a healthy family. Three years ago there had been some ulceration on the right thigh, which the patient attributed to cold, and which left a group of roundish smooth cicatrices. The trouble on the nose began two years ago, in the form of a small spot, tubercle, or other lesion on one side, which gradually increased till it had covered nearly the whole surface of the nose. It has never ulcerated nor caused any discomfort. It had the appearance of a neoplasm, which was sharply defined at the edges in the form of an elevated ridge or tubercular border. The general surface of the affected area was uneven, tuberculated, with here and there the appearance of cicatricial contractions. On one side were one or two quite circular depressed scars. When first seen, the surface was rather scaly, but the scales, when removed, did not seem to be of a sebaceous character and had no prolongations on their under surfaces, corresponding to any dilated crypts in the skin. The color of the lesion was a somewhat dusky red, but perhaps of a brighter hue than one would expect in a syphilitic affection. All other cutaneous regions appeared to be entirely free from disease, and the only trace of any previous trouble were the scars on the thigh.

DR. FOX in discussing the case stated, that he was of the opinion that it was a case of tubercular syphilis, an unusual one, it was true, but yet it had appeared to him as such on the first glance, and he thought that on closer examination the characteristics of the lesion would establish that diagnosis.

DR. JACKSON was of the opinion that the case was one of tubercular syphilis.

DR. ELLIOT did not think that syphilis could enter into the question. He regarded the lesion presented by the case as lupus erythematosus, and he thought that the course of the affection, and its objective symptoms, warranted that diagnosis. Dr. Bronson had said that it had begun as a single

lesion, which had enlarged slowly, and in a centrifugal manner, until, after two years, it had attained its present size. The border enclosing the space in which were the cicatrices was only slightly elevated, with a small amount of oedematous infiltration, red and uniform; the scars themselves were scattered here and there, neither grouped, nor continuous, and the sebaceous follicles were choked up with whitish plugs, which lent a roughened sensation to the touch. Dr. Elliot had never seen a syphilide which would correspond in any way to these features, but, in case that disease was present, would expect that in two years a very much more extensive space would have been implicated, that a seripignous and not a centrifugal development would have occurred, that the peripheral border would be composed of separate lesions, and that the cicatrization would be characteristic. He had seen and treated other cases of lupus erythematosus, which were counterparts of the present one, and, in his opinion, the patient was suffering from that disease.

DR. STURGIS said he thought also that the case was one of lupus erythematosus. The centrifugal development of the lesion was against syphilis.

DR. TAYLOR stated that he agreed with Dr. Elliot in regarding the affection as lupus erythematosus. The history of the case agreed with what one would expect in that disease, and the objective symptoms likewise. Lupus erythematosus was sometimes accompanied by oedematous swelling. Besides, a syphilide does not localize itself so completely as in this case, and, if situated on the nose for the length of time that this eruption has been, would be accompanied by ulceration, affection of the cartilage, and a sanious discharge from the nostrils.

Dr. Bronson said, in summing up, that had all the members of the Society agreed in their diagnosis, he would have been surprised, if not somewhat chagrined, for he regarded the case as in some particulars an anomalous one. There were three diseases among which he had believed the diagnosis laid, viz.: Lupus, lupus erythematosus and syphilis. The first had been easily eliminated for obvious reasons. Between the other two, he was still in doubt, though, on the whole, rather inclined to the side of syphilis. He had never seen a case of lupus erythematosus presenting such appearances as this did of neoplastic infiltration. Moreover, he had been unable to make out any such marked implication of the sebaceous follicles such as Dr. Elliot had spoken of. In lupus erythematosus, while the border often showed a certain elevation such as might be presented by an ordinary erythema, the interior surface was usually smooth, atrophic and covered by characteristic scales. Here the infiltration was general and more or less tubercular. To be sure, the tubercles were much less distinctly marked than in an ordinary syphilide, and at the borders were more in the form of a uniform wall of infiltration in many places, than usually characterized the tubercular syphiloderm. Moreover, in its course of two years' duration, one would expect to see a more seripignous character and some evidence or history of ulceration. Treatment, for about ten days, by means of a local mercurial application, had as yet had comparatively little effect beyond smoothing the surface somewhat and removing the scales. It was Dr. Bronson's intention to put the patient on general anti-syphilitic treatment, which had not yet been done.

DR. ELLIOT suggested that local treatment be not, however, used. It was well known how beneficially the ordinary Ungt. Hydrarg acted on lupus erythematosus, and, if used in this case, it might produce changes which could give the idea that the affection was a syphilide, whereas, he was convinced that it was not. He said that he had been treating a case since last May, which presented on the cheek identical symptoms as Dr. Bronson's patient did. The Ungt. Hydrarg. alone had been used and a great part of the disease had disappeared. If in his case it had been a syphilide, he

would have expected total disappearance in a month to six weeks by that treatment, whereas, six months' steady treatment had only removed about one-half of the objective lesion.

DR. TAYLOR said, in addition, that he had observed in cases in his clinic at the New York Hospital, where lupus erythematosus had been present for a long time, the plugging of the glands was not marked, and the prolongations on the under side of the scales was not found. He also called attention to the very great difference existing between the present case and the leontiasis due to syphilis, referring to the admirable representation of this latter condition portrayed in Cazenave's plates.

DR. JACKSON presented a case of

#### MORPHEA.

Miss W—, age 22, native of United States, a milliner. The disease began some ten or twelve months ago. It is located upon the head and forehead, beginning about at a point a little to the right of the median line of the head, and half-way between the vertex and the margin of the hair on the forehead. From here it runs forwards, a little outwards and then downwards over the forehead, to end at a point a little to the left of the middle of the right eyebrow. There is also a small spot of disease on the right eyelid. The main lesion is a stripe about seven inches long and from one-half to three-fourths of an inch broad. This has a yellowish centre, with a border in some places white and atrophic looking, and in others violaceous in color. The lower part of the lesion is hard and hypertrophic, feeling like a piece of bacon let into the skin, but at the upper part there is a place that is atrophied.

The disease began at the edge of the hair and from there spread up and down, but more rapidly downwards. It has apparently ceased spreading upwards. The hair has fallen from the places on the scalp which have been invaded by disease. The patient complains of some burning and itching in the patch, and suffers from intense headaches. Her general health is good.

In the discussion on the case Dr. Fox said that he had not seen the case before, but he would regard it as an example of morphea.

DR. PIFFARD thought that the changes presented by the patient were neurotic in origin, produced by some lesion of the supraorbital nerve.

DR. SHERWELL believed that from want of any clinical evidence of infiltration or history thereof, that he agreed with the last speaker, that it was a case of simple atrophy from neurosis.

DR. MORROW held that it was a neurotic atrophy. He stated that, though the aspect of the lesion might suggest morphea, it was lacking in the clinical features of that disease. There were none of those peculiarities of surface or outlying spots in this case which are presented by morphea.

DR. BRONSON said that in view of the vagueness that existed regarding the nature of morphea, it was doubtful whether it was proper to regard it as an independent form of disease, but clinically, he believed that such an affection did exist. He did not, however, think that the present case corresponded to that affection. He would call it simply atrophica cutis of neuropathic origin.

DR. ELLIOT said that he also would regard the affection as an atrophy of the skin, neurotic in origin. The case reminded him very much of several which had been under his care and which had followed upon severe supra-orbital neuralgia. In one of these, the area of atrophy was about one and a half inches long and a third of an inch broad. The surface affected was upon the hairy scalp, near the median line, and just beyond the junction of the forehead and the scalp. In another, the neuralgia had persisted three times weekly for eight years before any change had taken place. In this case

the atrophy extended down upon the forehead and there had developed over the affected branch of the supraorbital nerve, about midway between the foramen of exit and the margin of the hair, a spot as large as a pea and absolutely black. This spot had been slowly growing larger for the last six months. Dr. Elliot would regard such cases as the result of trophic changes.

DR. JACKSON, in summing up, stated that he was inclined to think that, notwithstanding the views expressed, examination by daylight would show that the violaceous border of the lesion was marked and that the case was morphœa.

DR. FOX presented a case of

#### CHRONIC ERYTHEMA MULTIFORME.

The patient, a man, had suffered from the eruption for thirteen months. The lesions are present on extremities and body. They first appeared on extremities and subsequently invaded the body. On the hands and arms and legs are papules and circinate lesions. There have also been outbreaks on these portions of the surface of bullæ and vesicles. On the body there are only erythematous rings and gyreæ. There is some itching. His general health is good.

DR. PIFFARD presented a typical case of

#### MORPHŒA,

in a young girl twelve years of age, in whom the affection commenced two years ago by a spot on left buttock. This increased in size, and is now about two inches in diameter. Other lesions subsequently appeared, and there are now about half a dozen, varying in size from that of a pea up to the one above mentioned. The general health of the patient was to all appearances good.

DR. LEWIS presented for diagnosis a case of

#### ULCERATION ON THE SCALP.

The patient, a man forty years of age, states that the disease began about ten years ago as a tubercle behind the left ear. This was removed, but a new lesion developed shortly after, and growing larger gradually and slowly, ulcerated about two years ago. Patient has been under treatment outside of the city for some length of time. When he presented himself for treatment here, it was found that the entire right half of the scalp, from the ear to the vertex, and from the occiput to the forehead was the seat of a diffuse ulcer. The ulceration extended also downwards upon the neck. The surface is covered with granulations and nodular growths. The granulations are in portions healthy, and in others flabby and unhealthy. There is a quite abundant secretion of pus, some pain and itchiness. The edges of the ulcerated surface along its lower margin are not particularly indurated, are somewhat elevated. The left ear is swollen, and has a waxy appearance. Beyond the margin at the vertex are waxy-looking patches, separated by darker lines on the same level.

The discussion of the case was opened by Dr. Fox. In his opinion the case was one of morphœa. He thought that the ulceration, which was now the most striking feature, was secondary and not to be considered in making the diagnosis. The condition of the skin beyond the ulcerated surface and near the median line seemed to him to present characteristic symptoms connected with morphœa. There was found at that place a firm whitish deposit in the skin, surrounded by a violet border, and there was also a condition which he had never seen but in one case, viz. : that it could be

observed on the surface how the patches of morphea, increasing in size, their violet borders ran together and formed a network. The case he referred to was doubtless still remembered by Dr. Jackson, and in that instance the appearance just mentioned occurred on the thigh. In Dr. Lewis' case, the same condition was, in his opinion, present, and he thought that if the patient was examined by daylight, the diagnosis of morphea would be made. The only point that could be urged against the diagnosis would be that ulceration does not take place in morphea. It does, however, in scleroderma, and for that reason it would not be entirely unexpected by him in morphea, inasmuch as he thinks that both of these are only stages of one and the same disease. He did not think it surprising that, the disease starting on scalp, ulceration occurred and progressed to the extent seen in this case.

DR. ALLEN said, that although the lesions on the now ulcerated side of the head looked like morphea in a measure, yet the marked enlargement, pain and tenderness of the glands upon the opposite side, made the case look more like one of malignant growth. Still he would prefer not to make this diagnosis.

DR. SHERWELL said that the present appearances were most like those of an epithelioma, but still he had doubts and would continue to have them in the absence of a microscopical examination. He believed with Unna, that some ugly appearing granulating surfaces, as in this case, might have been made so by excess of treatment, oxidizing in character—so-called dermatoplastic excess. He has had several such, and very recently one most marked case of this character. It was originally a localized eczema that had been so cauterized, etc., that it had become converted into a malignant-looking open sore, which he had almost made up his mind to extirpate. The history, however, having been a typical one of eczema, he preferred trying the "Reductions Mitteln," or keratoplastic treatment first, and applied a dusting of sulphur. The results were astonishingly good, perfect cure being obtained in a short time. He would be curious to watch the effect of similar treatment used for a while on this case of Dr. Lewis. Later in the discussion, it was asked by Dr. Sherwell, whether or not this extensive lesion might not have arisen possibly from an over-treated kerion of the scalp, application of caustics, etc.

DR. MORROW said that he had formed no definite opinion in regard to the nature of the disease in this case, but he certainly disagreed with Dr. Fox. There was nothing indicative of morphea in the cicatrices on the temple or beyond the margin of the ulcer, and there was also no record of morphea presenting such a peculiarly ulcerated condition. Moreover, it was rare to find morphea in that locality; it was more commonly situated on chest and extremities, being unilateral or bilateral, but not occupying the median line. He thought that it would be difficult to form an opinion in regard to this case, because the lesion had been so essentially modified by treatment. He had found that some skins reacted strongly to even mild agents. He had lately had under his care a patient who had treated a palmar eczema with "Cuticura." An eruption very much like the one in this case had been caused. It extended over the palms, upon and between the fingers, and was fungoid in character. He thought Dr. Lewis' case resembled somewhat what had been described under the name of fungating disease of the scalp, the fungating appearances having been kept down, however, by the treatment.

DR. BRONSON stated that he could not coincide in the view that the disease was morphea, nor could he believe that the appearances were in any material degree the result of treatment. It appeared to him that the condensation of the tissues at the border of the ulcerated area would account for the necrosis, through interference with the circulation in the blood ves-

sels and the lymphatics. The infiltrated nodules and wall about the diseased area seemed to him evidence of a neoplastic character.

DR. ELLIOT said that he had seen the patient when he first presented himself for treatment at the hospital, and having examined the diseased surface carefully by daylight, had concluded that the condition present was a cancerous one. He thought, however, that a portion of the ulcer, that nearer the vertex, was a granulating surface resulting from the treatment that had been made use of to further the healing of the wound produced by the knife or cauterizing agent. He had based his diagnosis upon the history, the extirpation of the first growth, its recurrence some time after and slow course, the character of the edges and the implication of the glands and the tissue around and about the ear for some distance beyond the ulcer. What form of cancer it was he would not attempt to determine without the aid of the microscope. In his opinion, morphœa was not present, but the surfaces suggesting that disease were cicatrices, the result of treatment applied where the disease had been.

DR. TAYLOR said that his opinion leaned towards epithelioma.

DR. LEWIS, in summing up, stated that he had made the diagnosis of epithelioma in this case, owing to its history and cause. He thought the border was characteristic of that disease, and it was due to the treatment that in some places the usual objective symptoms were wanting. He did not think that the general good condition of the patient was anything unusual. He had already shown cases to the Society in whom, though epithelioma had been present for many years, the general health was just as good.

DR. PIFFARD then read a paper on

#### CUTANEOUS PHOTOGRAPHY MADE EASY<sup>1</sup>

and demonstrated the method described. Dr. Fox, in discussing the paper said that he hoped that the method of taking photographs, detailed by Dr. Piffard, would give us the opportunity of obtaining representations of all of our interesting cases. He thought that it had still to be proven that it was as good as sunlight and that the short time of exposure was as good as a longer one. The majority of the photographs taken by Dr. Piffard's process and shown to-night, he did not think were as good as those which Dr. Piffard might take with sunlight and longer exposure.

DR. BRONSON thought that the thanks of the Society were due to Dr. Piffard for his interesting communications, and believed that the method displayed might be of great value in the photography of skin diseases.

In summing up, Dr. Piffard said that the opinion of practical photographers, in regard to the process described in the paper, was that by means of it increased modeling and details were obtained, in comparison with the sunlight process.

The Society then went into Executive Session.

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## Selections.

### SOURCES OF SYPHILIS IN WOMEN.

PROFESSOR ALFRED FOURNIER (*Bul. de l'Acad. de Med.*, October 25, 1887) presented a statistical document to the Paris Academy of Medicine at the meeting of October 25th, to demonstrate that syphilis is not the exclusive result of vice and debauch and is confined to those who expose themselves to it. The idea that such is the case must be strenuously opposed,

<sup>1</sup> See page 41.



and those who believe that syphilis does not seek out any victims, but must be sought for, should be shown their error.

Out of a given number of syphilitic women observed under similar conditions, how many are there who have derived the disease from an unmerited source? How many times each one of us has seen married and respectable women who suffer from the fault of their husbands, children who have innocently received the disease, nurses who have contracted it from these children, and carried it to their own little ones at home and to their husbands? We shall not now speak of those lamentable cases of professional contagion of which physicians, nurses, midwives and students are so often the victims.

The problem is insoluble in hospital practice where the patients are not known, and their declaration is all we have to guide us and cannot be verified. It must be settled by the statistics of private practice. During the past twenty-seven years Professor Fournier has treated in his office 887 women affected with syphilis. These can be classed in two groups.

1. Cases of syphilis of sexual origin, 842.
2. Non-venereal syphilis, 45.

These forty-five are made up of a variety of cases having nothing in common but the fact of a non-venereal origin. Among them are found seven cases of hereditary origin; four of syphilis accidentally contracted in infancy; eight cases of infection transmitted to nurses from infants having hereditary syphilis; five cases of midwives infected upon the fingers in the discharge of their professional duties; twelve cases of domestic contagion derived from infants, children, nurses or servants who had the disease.

Two cases of syphilis transmitted by vaccination. Two by catheterization of the eustachian tube.

One case consecutive to rape. Four cases doubtful but of an origin certainly foreign to all venereal contamination. These constitute the class of syphilis of the innocent (*syphilis incontinentum*), and certainly deserve the qualification of *unmerited syphilis*.

The group of 842 cases was made up in the following manner: 366 of the women belonged to the irregular class; 220 were married; 256 were of an unknown social condition. A careful calculation, after eliminating doubtful cases, shows that out of one hundred women affected with syphilis, eighty-one belonged to the category of its irregular class and only nineteen were married.

This proportion Professor Fournier thinks does not even express the whole truth of the matter, extraordinary as it appears.

Adding to these nineteen cases the number of five per cent. as representing the proportion of syphilis not venereal in origin, we have a total of twenty-four per cent. of cases of unmerited syphilis.

Here, then, is a strong argument in favor of public prophylaxis, which in reality would be offering protection to all classes.

Diminishing the number of venereal cases decreases at the same time the resulting innocent infections.

### DIAGNOSIS AND TREATMENT OF TUMORS OF THE BLADDER.

THE symptoms furnished by the presence of a neoplasm in the bladder, were but a short time ago considered vague and often left the diagnosis in doubt.

Better understood, they permit us to-day to recognize the presence of a tumor with a great degree of surety, and undertake operations either radical or palliative.

The pain caused by a neoplasm in the bladder constitutes a symptom of but slight value; first, because it appears rather late and long after the diagnosis should have been established by other symptoms. It is almost constant, efforts at urination do not increase it unless there be a concomitant cystitis. We shall see that the violence of the pain is almost entirely independent of the nature of the tumor, contrary to the assertion of Thompson, that it is an index of the cancerous nature of the growth.

Amongst all the symptoms there is one of paramount importance, it is hæmaturia. Professor Guyon has especially called attention to its importance, and says that where bloody urine appears without appreciable cause there is cause for suspicion. If it persists in spite of repose, a quasi certitude is established; so too, if it disappears and appears again without any observation to explain it. Finally, it takes on a pathognomonic character when its period of duration increases and its reappearance becomes more frequent.

There is a spontaneity about the attacks not influenced by violent jolting, shocks, etc., and not improved by repose, but rather increased by congestion of the urinary apparatus. Rectal touch and the use of the catheter are required to determine the location of the tumor, if in the bladder. Exploration by the rectum, or in women by the vagina, is the more valuable, as giving an idea of the condition of the bladder walls and the volume of the tumor. The sensation is usually given to the finger of a series of projecting masses of various dimensions, more or less resistant. The sensation may be quite vague, and not readily appreciated. Hypogastric palpation, especially when combined with the rectal touch, also gives indications relative to the volume of the tumor, and when the mass is considerable, and the urine has been evacuated, then it may be grasped between the finger in the rectum and hand above.

If the greater part of the urine is passed clear or only tinted with blood, and the last few drops are almost clear blood, we have an almost sure sign that the bleeding proceeds from the bladder, especially if the same thing occur after intra-vesical injection. Too much must not be expected from the exploring sound. At times the instrument passed over the mucous lining of the bladder permits us to feel a soft grazing, which Dr. Guyon expresses as resembling the contact of the instrument with a silky beard.

The combined exploration with catheter and rectal touch gives a greater certitude in some conditions. The point of the instrument, separated from the finger by the thin walls of the healthy portion of the bladder, is widely separated in the portion occupied by the tumor. The information thus obtained only confirms that of other symptoms.

If the intra-vesical manipulations have produced an increase of the hæmaturia, it is an additional proof that the neoplasm is seated in the bladder.

If the kidneys are the seat of the disease, an increase in their volume may be made out. Professor Guyon has well shown that the kidney becomes movable by the very fact of its enlargement. In introducing one or two fingers between the last rib and the iliac bone, and in placing the other hand flat upon the abdomen, slight impulses given by the fingers bring the kidney

into contact with the abdominal wall, opposite the palm on the abdomen; this he has called renal *ballottement*.

Symptomatic varicocele is another sign of renal neoplasm. A varicose condition of a vein appears, which often takes on extensive proportions in consequence of the obstacle made to the return circulation by the enlarged kidney. Pains, simulating nephritic colic, are also often present.

Thompson's exploratory incision is surrounded with great difficulties. Dittel has devised a very ingenious cystoscope, with an electric light, by the aid of which a great part of the vesical walls can be lighted up and made visible. A liquid medium is required for the proper employment of the instrument, and as we have seen how readily these tumors bleed, the transparency of the bladder contents would be lost by a few drops of blood and the endoscope most likely fail to give valuable aid. Kuster's process of introducing a sound having an eye with a cutting edge, by the means of which portions of the tumor are cut away for microscopical examination, is, despite the assertions of the author and others, a dangerous method of exploration. The first surgical treatment of bladder tumors was attempted only upon patients in extremis, but now some advise operation as soon as the diagnosis of a probable tumor is possible. Hæmaturia, by its abundance, or its persistence, often constitutes an immediate danger to life, and the pain may be so intense that an operation becomes imperative. The simple opening of the bladder procures a lasting amelioration; in taking away the function of the organ the hæmaturia is arrested. The removal of the tumor should always be attempted, for even if incompletely done, the fatal issue is put off. In cases where recurrence has been most rapid, months have passed before the growth has attained its original volume. Radical cure is most rare and most difficult to effect. To procure it, resection of the bladder wall is necessary, and this resection is almost always impossible because of the usual situation of the tumor in the trigonum, which does not permit of total extirpation without injury to the urethra. Furthermore, these growths are usually malignant and the walls are infiltrated.

The existence of benign papillomata is undoubted, and as they may take on a cancerous nature, early operation is in this event preferable. An incomplete operation is attended with much danger, and may render the process more active. The course of these neoplasms is extremely slow, and in certain cases extends over ten, fifteen or more years.

The utility of early intervention is far from being demonstrated, and it is more in conformity with the indications furnished by the symptoms and clinical features, and open the bladder only when the patient's life becomes exposed to a real danger, or when the pains have become extremely violent. As to method of operation, we shall consider only urethral dilatation and perineal section, as we have but recently described the hypogastric operation.

The first is only applicable to operation in women. The dilatation may be accomplished by the aid of Professor Guyon's graduated tents, or Hégear's dilating bougies. The urethra can be easily stretched to a diameter of two centimeters, permitting the introduction of instruments sufficient for the removal of the tumor, but it cannot be seen whether the extirpation has been complete, and an accident during the operation cannot readily be remedied. The same objections can be raised to Thompson's perineal operation. Here an incision, beginning two centimeters in front of the anus,

extends four centimeters in length to reach a grooved catheter previously introduced into the urethra, and opens up the canal in the membranous portion. The finger is then gradually introduced into the prostatic portion, which it dilates, and passes into the bladder. This permits of an almost complete exploration in slender subjects, and the introduction of a variety of instruments. The same precision is not guaranteed by this method as by the hypogastric operation, but it is rapid and safe. The recent perfections in this latter operation permit the surgeon to see the interior of the organ, and methodically remove the tumor. Again, this operation, more than any other, leaves the organ in a state of repose, takes away congestion and pain. Great precautions are necessary, it is true, to assure success, but there are no serious difficulties, and in prudent hands the dangers are scarcely greater than in the perineal operation.—Dr. Desnos, *Le Concours Medical*, Oct. 22, 1887.

### URETHRITIS INFECTIONOSA.

DR. PETERSEN (*St. Petersburg Med. Wochens*, Sept., 1887) thinks the weakest point in the therapy of gonorrhœa is found in the gonorrhœal syringe; first, because the opening is so small that only a moderate stream can be used, which only comes into contact with a portion of the mucous membrane, and may even work injuriously; and, secondly, because the amount of pressure to be employed is left to the patient. The author employs a urethral irrigator, which he regards as much more preferable.

### SYPHILITIC ACNE OF THE NOSE.

DR. HORAND (*Lyon Medical*, Oct. 16, 1887) describes a syphilitic lesion of the nose which, he says, is not spoken of in works of dermatology and syphilography. Syphilis, as well known, has a tendency to show itself in the region of the nose, especially in the tertiary period. This lesion is often quite difficult to differentiate from other affections of the skin in the same situation, such as acne rosacea, chronic pustular acne, impetigo, lupus and cancroide.

The author has observed thirteen cases of this rare manifestation of tertiary syphilis, and gives its chief characteristic, the existence of isolated or grouped pustules.

Those which are isolated have the volume of a lentil, and a cone shape. At their summit there exists a yellow spot or a brownish crust. Their base is surrounded by an areola of a bright red color. If the crust is removed, an ulceration of the derma is found underneath it, covered with a grayish pus. Between the isolated or grouped pustules the skin is thickened and presents here and there whitish cicatrices, resembling exactly those of variola. The nose is increased in size. The affection is not painful. The sub-maxillary ganglia are not engorged.

The following description is taken from some of the cases reported.

The patient had contracted a chancre in 1867 which had left behind a cicatrix. The lesions of the nose had first appeared in 1882 under anti-syphilitic treatment, the patient recovered and for two years has been well, the nose being somewhat disfigured by cicatrices resembling those of small-pox.

The second case reported was one in which a lesion upon the nose of a woman had been for some time treated as a lupus, and had been scraped, scari-

fied and burned without benefit. Under daily dose of a grain of iodide of potassium it soon entirely disappeared, but other signs of syphilis subsequently showed themselves. In this case the nose and upper lip were occupied by a pale red patch on which papules of the same color and of a soft consistence were situated; there were also some yellow crusts which were easily detached and disclosed slight ulcerations covered with a layer of pus. This cutaneous manifestation of syphilis affects by preference the ala and lobe of the nose, although at times it extends to the neighboring regions of the cheeks and to the upper lip, but is ordinarily arrested at the root of the nose and does not affect the mucous membrane, the cartilage or the bone. *Acne indurata* is strongly suggested by the appearances presented.

Some lesions contain pus, others are covered with blackish crusts. At times they remain isolated, and at others run together or break down and produce a rounded ulceration with regular borders and a scooped-out gray colored base. The dimensions vary from that of a pin's head to the size of a five-cent silver piece. There is little secretion from the ulcer, which becomes covered with a blackish crust. The scattered pustules are situated upon a dark red, thickened, pasty base, with intervening cicatrices, which are red or white according to their age and the result of previous pustules.

The nose is increased in size and deformed, but not painful or tender. The submaxillary glands are not influenced by it. The commencement of the affection is characterized by a redness of the lobe or ala nasi and the appearance of a pustule. In proportion as the redness extends the number of pustules increase and the skin thickens. As new pustules develop, old ones rupture, ulcerate and some cicatrize, but there is but slight tendency to spontaneous cure, and may last for years, other manifestations of syphilis being present or absent. As to frequency, the author says he has observed but thirteen cases in eighteen years' practice, nine cases having occurred in 3,010 cases of syphilis.

It is therefore rare, but a little more frequent in women than in men. It is a late manifestation never met with before the third year, and appearing as late as fifty years after the chancre. Its development favored by lack of treatment early in the infection, and especially by alcoholism. The prognosis is only bad as regards cicatrices.

Anti-syphilitic treatment produces the most happy results. As to other affection found on this region with which it might be confounded, the most important is surely *acne rosacea*, which is essentially characterized by patches of a bright red or violaceous color over which run small bluish veins, and has elevations separated by fissures. The examination of the lesions will remove all confusion of diagnosis. It is also easily confounded with *acne indurata*; but this does not appear upon the nose alone, but also upon the cheeks, forehead, etc., and has a preference for early life. The pustules have a red color at first and then become violaceous, and in disappearing leave hard nodules whose slow resolution often remain incomplete.

Impetigo may also be confounded with this eruption, from the crusty aspect presented on superficial observation; but underneath the crusts in impetigo there is only redness or simple erosion, and this disease is rarely localized upon the nose. It is true, an *impetigo-rodens* has been described, but is allied to lupus, and lupus attacks young people, and there are not found pustules in various stages of evolution. Finally, the affection is distinguished from lupus by treatment. *Cancroïde* has a unique form of ulcer-

ation, is usually situated upon the side of the nose, has an indurated border, secretes a sanguineous serosity, and is attended with lancinating pains.

General anti-syphilitic treatment with the iodide of potassium is requisite in doses as high as ninety grains as day. Boiled starch poultices, either hot or cold, are useful to detach the crusts, etc., and the application of tincture of iodine is sometimes useful to prevent pitting. The duration of treatment does not exceed two months.

### **ON THE TREATMENT OF PSORIASIS BY LARGE DOSES OF THE IODIDE OF POTASSIUM.**

In the year 1881 Greves recommended iodide of potassium for psoriasis, regarding it as a drug possessing much greater influence in causing the disappearance of chronic inflammatory products than was generally supposed. He advised beginning a course of treatment with a solution of ten grains of the iodide to three hundred grains of water, of which a desert spoonful was to be taken three or four times daily. At each renewal of the prescription the solution is to be made five grains stronger, and thus increased until thirty or forty grains to three hundred of water have been reached. He never prescribed more than one spoonful four times a day, so that the patient never gets more than ten grains daily.

Haslund began his experiments in the manner proposed by Greves, and while the patient supported the drug well, soon increased the dose materially.

The method which Haslund followed was usually to begin with a solution of ten grains of iodide to two hundred grains of water, of which a desert spoonful was administered four times daily. Small children began with a solution of five grains to two hundred of water, but were soon placed upon the stronger solution. After two or three days six doses were given daily, and two days later, eight, and so on until the patient was taking twelve spoonfuls, or the whole contents of the bottle in the course of the day, two spoonfuls at a time six times daily. If a patient had taken, for two successive days, the whole bottleful, the author every second or third day made the prescription two grains stronger and ordered a glass of water to be taken after each dose. Some patients went so far as to consume, in the space of two or three months' time, the enormous quantity of from 1,827 to 2,256 grains of the iodide of potassium. The maximal daily dose varied in the rule from twenty to fifty grains.

The result of this method of treatment was in fifty cases as follows: In forty a full recovery was obtained, in four there was decided improvement, and in six no benefit was obtained. The average duration of treatment in the cured cases was a little over seven weeks.

There was considerable variation in the time at which a disappearance of the psoriasis began. In some cases it was noticed as early as the seventh to tenth day, while in others four or five weeks passed before the lesions began to disappear. One patient took as high as thirty-five grains before an effect could be made out.

These large doses of the iodide were well supported. In ten cases there were slight signs of iodism in the first few days, such as headache and coryza and slight digestive disturbances, with nausea, cardiac oppression, loss of appetite, and diarrhoea. In one case there was a decided salivation produced; but in none of the cases was it necessary to interrupt the course of treatment, but only to increase the dose more slowly.

In seven cases digestive disturbances appeared necessitating the decrease of the dose one-half, and in a few cases was it necessary to stop the drug entirely. In a few cases the patients had headache and dizziness, in one patient the pulse was one day irregular, two developed albumen in the urine, which in one case persisted for eight days, but in the other had disappeared by the next day without the iodide being stopped. The only severe case of iodism occurred in a man of thirty-seven, who, after reaching fifty grains a day, became dull, confused and unable to collect his thoughts, had headache and roaring in the ears. His conversation was rational and all the functions in the best of order, and the appetite was good. The face somewhat bloated. The iodide was at once stopped, but during the night palpitation of the heart came on attended with difficult breathing. In two days the symptoms had all subsided. At the completion of the course of treatment most of the patients left the hospital presenting a healthy appearance. In two cases the bodily weight was unchanged; in twenty-eight cases it had increased from three to seven thousand grains, and in time of the cured cases there had been a loss of from a hundred and fifty to five thousand grains. A decrease in fatty and glandular tissues could not be established. In the only female patient subjected to three large doses, there appeared rather to be an increase in the size of the mammae. The author concludes from all these observations that we possess in the iodide of potassium a drug which, if given in large quantities, will cure an outbreak of psoriasis with comparative safety, and that we possess no other drug which will effect a cure in so short a time, arsenic beginning to show its curative effect only after about six weeks.

In regard to recurrences of psoriasis after the treatment by the iodide of potassium, the author reserves his decision, but it would appear that his method would exercise no great influence. (*Virteej. f. Derm. u. Syph.* 1887 3. H.) Jarisch in the *Centralblatt für die Gesam. Therap.*, Sept., 1887.

### THALLIN IN GONORRHOEA.

DR. GOLL, of Zurich (*Korr. Bl. f. Schweizer Ärzte*, Nov. 1887), regards the salts of thallin, and especially the sulphate of thallin, as an effectual and but slightly irritating antidote to the gonococcus virus.

He has also employed the tartrate of thallin in one and two per cent. solution in recent cases of gonorrhœa without waiting for the inflammatory stage to pass entirely. It appeared to act well, first changing the purulent secretion into one of a milky or slimy nature, which in turn disappeared.

Still more active and beneficial was a two and two and a-half per cent. solution, although in some cases this caused some inflammatory symptoms.

In the chronic stage he employs a solution of from one to one and a-half per cent. as an irrigation with favorable results.

DR. KRIS, also of Zurich, writes in the same journal that he was led by the observations of Schulz and Pisenti relating to the antiseptic nature of thallin to try its effects upon gonococcus cultures:

- 1st. By bringing a solution of thallin into contact with flat cultures, and
- 2d. By inoculating media containing thallin with gonorrhœal pus.

In the first, two series of experiments were made, one with an acid and the other with a neutral solution. In all the trials no gonococci developed.

In the second experiment the medium prepared with thallin solutions (neutral and acid) were inoculated with cultures of gonococci and placed in

the hot air chamber; the result was that no gonococci developed, while a control experiment at the same time carried out in a medium free from thallin showed, after twenty-four hours, commencing development of typical gonococci. The strength of the thallin solutions used were from one-half to four per cent.

### ANTISEPSIS OF THE URETHRA AND BLADDER IN STRICTURE.

DR. LAVAUX read a paper before the French Academy of Medicine, Oct. 29, 1887, on a mode of antiseptics of the urethra and bladder, and its application to the treatment of urethral stricture. The following résumé of his conclusions are given in *Le Progrès, Médical*, Nov. 12, 1887:

1. Continual washings of the anterior urethra and intra-vesical injections without a catheter constitutes a simple and inoffensive means to secure complete antiseptics of the bladder and urethra.

2. This method is applicable to the most part of urethral strictures.

3. Thanks to this complete antiseptics, and to the anti-phlogistic action of vesical injection without catheter, complications due to rapid dilatation are now quite rare.

4. In the treatment of strictures which are simple and easily dilatable, rapid dilatation should be substituted as a general thing to the slow method of dilatation, which has scarcely any more a *raison d'être*.

5. Intra-vesical injections without catheter are sufficient to maintain the calibre of the dilated urethra.

6. The indications for internal methrotomy become extremely restricted.

7. Continual washing of the anterior urethra and vesical injections without catheter, permitting complete antiseptics of the bladder and urethra, should render divulsion and internal urethrotomy much less grave operations.

### ON THE PRESENT KNOWLEDGE OF THE THERAPY OF CYSTITIS.

THE difficulty of treating cystitis depends upon the fact that the nature of the separate varieties of the disease is so different. They vary first in duration, second in localization, third in extent, and fourth in the causative nature of the inflammation. In acute cystitis, prophylaxis plays an important role (rational treatment of gonorrhoea, strict antiseptics in the introduction of instruments, etc.). We distinguish a light form which pathologically is represented by a cystitis mucosa, and a severe form in which the inflammation extends into the deeper parts. Against the first, three varieties of treatment are in use; the antiphlogistic, of which the abstraction of blood by leeches is the most effective. Second, calming means, and among them sitz baths occupy the first rank. When these do not sufficiently affect the case, narcotics in free dose must be given, under the influence of which the bladder contractions diminish both in number and force. Third, such drugs as exert an influence upon the mucous membrane of the bladder itself, and should cause an alteration in the urine; and here, first of all, must be insisted upon an unirritating diet. The great things expected from antiseptics have not been fulfilled. Acute gonorrhoeal cystitis occupies a peculiar position, in so far that here, contrary to the custom in other acute forms, the introduction of instruments into the bladder with the object of carrying out an energetic



local treatment has its place, Guyon and Dittel having developed the method in cauterization of the neck of the bladder.

Still further energetic means are required in the very severe acute cases of cystitis, in which one does not desire to delay; the contractions of the bladder may be suppressed and the urine given uninterrupted exit by the operation of high or median section.

In chronic cystitis the therapy resolves itself into hygienic, internal, and local treatment and operative procedure. Among the hygienic means we have as the most important, a strict unirritating diet, and the avoidance of taking cold.

The internal treatment comprises means to ease the pain, and those which have an influence upon the bladder mucous membrane and alter the nature of the urine. If these means all prove ineffective, local treatment by means of the catheter takes the foremost place, and from the many solutions which are recommended for washing out the bladder, a three per cent. solution of boric acid is the best supported.

In spite of the numerous remedies at our command, many cases are not at all improved or are even made worse. When the ammoniacal urine persists, the insufficiency of the bladder renders catheterization frequently necessary and disturbances of the general health appear, we must resort to the opening of the bladder, thus securing a continuous draining of the bladder and absolute rest of the inflamed organ, rendering the decomposition of the urine impossible. In women the forcible dilatation of the urethra answers the same purpose under the same circumstances.

In cystitis which has developed in consequence of malignant disease, all topical applications should be withheld, and by the use of hygienic, strengthening and calming means, endeavor to do more for the patient's general condition than for the local affection.—*Deutsch, Med. Zeitung.*

### HEMATURIA. VESICAL NEURALGIA.

In the clinical conferences of Professor Guyon at the Necker Hospital interesting cases of hematuria have recently been shown. In cases where there is much blood passed anemia may be very rapid, and it is probable that a tumor is the cause and also brings about a cystitis and even a nephritis. At times too the tumor may occlude the ureter, but neither the cavity of the ureter of the urethra is ever invaded; the same is true of the prostate, and conversely, primary cancer of the prostate never enters the bladder. The absence of lymphatics explains this freedom from propagation.

One patient in the service presents the rather rare condition of vesical neuralgia attended with great pain and exaggerated micturition. Painful phenomena, referable to the urethra and glans, are added to make up the habitual picture of vesical neuralgia. It is mostly observed in neuropaths, and more frequently in men than in women, though the contrary would be expected. Some cases suffer from affections of the cord and some are decidedly tabetic. Even in the most painful case where there is an affection of the cord the pain is not so violent as in some painful cystitis. In true neuralgia we often find along with nervous antecedents the history that the patient has formerly urinated in bed. To exclude cystitis the urine must be examined. For cystitis to exist three factors must be present: frequency of urination, pain and altered secretion. The pain in neuralgia is peculiar in

that it is absolutely independent of an inflammatory condition. Direct or indirect exploration shows the bladder to be indolent.

Every neuropath shows in the normal condition of the urethra an exaggerated sensibility in the membranous region which has led Professor Guyon to say that a man's character is known by the exploration of his urethra. Once passed this sensitive region the sound produces no pain in the bladder. The majority of cases described as neuralgia belong really to the class of painful cystitis or the tuberculous or gonorrhœal variety.

The prognosis is subordinate to the cause. If of simple neurotic origin, the prognosis is not grave. If hereditary antecedents are a factor it is more serious. In every case complications in neighboring organs must be sought for, such as rectitis, hemorrhoids fissures, and renal changes which might contribute to the persistence.

True, neuralgia is especially justifiable of general treatment, nevertheless certain patients find ease in having a metallic instrument passed—and this should be tried. In treatment the important point is to differentiate between painful cystitis and severe or mild neuralgia; the severe form generally being associated with an affection of the spinal cord.—*Journal de Méd. et de Chirurgie prat.* Sept. 1887.

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## Items.

**ARTHRITIC DERMATOSES**, when complicated with moist asthma, Bazin says, are benefited by the iodide of potassium. If rheumatism, gout or neuralgia are present, we may resort to salicylic acid or the salicylate of soda.

**SCABIES** is treated by Lassar with the following ointment: Naphthol, 5 to 10 grams; green soap, precipitated chalk, washed sulphur and lanolin, each 25 grams.

**PROLAPSE** of the urethral mucous membrane was found by Dr. Dorffmeister (*Deutsch Med. Zeit.*) in a nine-year-old girl, who had showed signs of scrofula. There was a large red tumor occupying the vaginal orifice, slightly excoriated, and the symptoms consisted in hæmorrhage, frequent calls to urination and pain.

The condition was explained by the discovery that the patient had had connection with a small boy, and as the hymen was found intact, it was surmised that the penis had been forced into the urethra. The constitutional affection is regarded as predisposing to the accident.

**THE NATURAL FLOW OF URINE** may be stopped, according to Ultzmann (*Intern. Klin. Rundsch.* 9-17, 1887).

1. By occlusion of the smaller urinary tubes, as in cholera and any of the kidney diseases.

2. By occlusion, twists, and turus in the ureter. (A man of forty-three years who had calculus of the kidney suddenly developed anuria, which in two weeks caused his death. Autopsy revealed a cyst of the left kidney the size of a goose egg, with obliteration of the ureter, and on the opposite side an enlarged kidney, and three small stones, filling the lumen of the ureter completely.)

3. By a tumor of the bladder.

JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

MARCH, 1888.

No. 3.

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**Original Communications.**

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**TUBERCULAR SYPHILIDE OF THE AURICLE—BECOMING SER-  
PIGINOUS WITH ULCERATION AND SEQUESTRATION OF  
THE CARTILAGE OF THE CONCHA, TRAGUS AND  
CANAL—FOLLOWED BY MEMBRANOUS  
ATRESIA—DEAFNESS—OPERA-  
TION—CURE.**

BY

ROBERT BARCLAY, M.D.

**M.** H—, aged thirty-two years, an American, of German parentage, a teamster by occupation, presented himself for treatment, on April 29, 1886, to his family physician, Dr. F—, who has kindly furnished me with this early history of the case:

When first seen, the patient had been employed as teamster on a coal wagon. He is, and has been from boyhood, a hard drinker of spirituous liquors. "Years ago" he contracted syphilis. Intense anxiety regarding the inflammation of his left auricle prompted the patient to seek medical advice. The ear has not been in the least painful. The upper portion of the auricle presented a black, charred surface, which had been supposed to have developed suddenly, and the attending physician, knowing the vocation of the patient, at first suspected this phenomenon to be due to want of cleanliness. No history of traumatism of any kind could be elicited. The discoloration spread rapidly, traveling from above downward

and inward toward the external auditory meatus. Some five days afterward the "charred" surface began to rise and separate from the posterior epidermis, and a muco-serous fluid exuded. A removal of the "charred tissue" followed, leaving a rough granular surface. About the end of the second week, the cartilage of the canal, tragus and concha, was removed in one piece (*see cut of sequestrum*) by simply lifting it out with a small pair of forceps. No pain had been experienced from the outset of the disease, except when some of the local medicinal applications were made. Treatment consisted in cleansing the parts with tepid water and soap, with subsequent applications of olive oil. The removal of the blackened and dead tissue began on the fifth day of treatment, and continued up to about the end of the second week. During the time of desquamation the denuded surface was washed carefully with tepid water, gently dried with absorbent cotton, and one of the following preparations tried, without success: carbolized oil, iodoform, a mixture of subnitrate of bismuth and oxide of zinc and an aqueous solution of chloral hydrate (gr. iij to  $\mathfrak{z}$ j.). There was then tried an ointment composed of bichloride of mercury, iron, sulphur, wax and cotton-seed oil—the proportions of which were not recorded—and this brought about a healthy reaction in the parts involved, causing no pain when applied. The canal was tented to prevent stenosis or atresia; but the patient being extremely careless, removing the tent by washing, as he says, becoming intoxicated, and failing to replace it for a period of six to twelve hours at a time, brought about unsuccessful results. Though no pain was suffered, there was deafness with the complete atresia that followed about the last days of July, 1886.

About May 2, 1887, he again presented himself for treatment to Dr. F——, with trouble in the same, the left auricle. It appeared as if a membrane had been tightly stretched over the whole external ear, looking "like a shining piece of light brown elastic, convex in form, bulging from the centre." The patient stated that this had developed slowly and was more or less painful at that time (doubtless because of pressure from the pent-up discharge). Incision gave vent to four to six drachms of pus, with relief to the patient, who exclaimed: "I can hear again!" The canal was not found on probing and nothing was made out except a raw surface. The auricle looked like anything but an auricle excepting its outline. The parts were cleansed, dried, and the compound ointment last used again applied. The patient was given internal administration of iodide of potash and bichloride of mercury. The parts healed again with no opening whatever, and the patient seemed to have average hearing in the affected ear. There has never been hemorrhage or pain except as stated above. The ear was

entirely closed again on May 23, 1887. No other syphilitic lesion was observed during the time of treatment of the aural inflammation.

The patient was first seen by me on September 8, 1887, in consultation with Dr. Wm. A. McCandless. The history and statements made by the patient himself differ somewhat from the preceding ones, and for want of space are omitted here. He, however, stated that the sequestrum was removed from his ear

Fig. 1.

eight months ago or thereabouts. (*The central object in Cut II. [actual size] is a view of the sequestrum, looking inward, the specimen being tilted a little forward of the anatomical position.*)

The left auricle presented the following appearance: general outline, normal. The first abnormality to strike the attention was the peculiar deformity of the concha—the upper and lower extreme limits of which were preserved—and the absence of the tragus and meatus. The beginning of the helix above was at an oval pit in the concha; and the intertragal notch below was a circular pit (*indistinctly shown in Cut I.*). There was a shining, bulging yellowish spot—resembling somewhat a sebaceous cyst—right over the site of the normal meatus, upon

a strong band of cicatrical tissue extending downward and backward from a spot above and in front of the site of the normal tragus, which band completely closed the meatus, and, with the exception of the oval and circular pits above described, completely filled the concha. Except a slight tightening of the skin, a seeming loss of subcutaneous tissue on the anterior side, and a slight drawing outward and forward of the auricle, it was otherwise apparently normal. Above, and anterior to site of normal tragus, and near that of the temporo-maxillary articulation, was a stellate cicatrix.

The patient complained of autophonous symptoms, tinnitus, occasional dizziness, fulness in head and ears, frequent dull pain, sometimes throbbing, and deafness, which interfered with the performance of his daily duties. He hears indistinctly by aërial conduction, a large C tuning-fork placed close to the seat of the normal meatus of the affected ear; and by bone conduction hears it distinctly in this, left, ear. He hears very loud voices spoken close to the left auricle. Hearing apparently normal in the right ear.

With the consent of Dr. McCandless, an incision was made into what was supposed by me to be the seat of the normal meatus—the lower portion of the bulging pus sac—and this gave exit to an amount of sero-purulent fluid, which, by careful syringing, came freely away. The discharge had apparently filled up the entire meatus, and consisted of sero-purulent fluid, in which, in great abundance, were cakes and flakes of pus, desquamated epithelium, and other decomposed tissue. After syringing until the solution came away clear, a probe was carefully passed inward to the depth of one and one-half inches. Insufflation was made of boracic acid and calendula, and a tightly rolled tampon of absorbent cotton wool inserted. Calx sulphurata, in small doses, was administered internally.

*September 9th.*—After removing the tampon the discharge was found greatly diminished, clearer. With a scapel, the cutting edge directed upward and forward, and point inward and forward, the opening was enlarged so that a Gruber aural speculum, next to the largest size, could be inserted. After careful cleansing and drying, was seen what appeared to be the membrana tympani, of which the processus brevis mallei and dimple of the umbo alone could be identified. This membrane was intensely macerated, and upon it were spots as if of adhering raw flesh. The canal was greatly enlarged, and its walls raw-looking. Hemorrhage from the cut surface of the new tissue was obstinate, refusing to cease on application of pressure, hot water or alum. It was finally checked by pressing against the bleeding surface a pledget of cotton wool, saturated with dilute Monsell's solution, which caused pain. Same dressings and internal treatment as before.

*September 10th.*—Discharge diminishing. Edges of the wound raw and covered with healthy pus. The opening already shows a tendency to contract. Application made of powdered boracic acid and calendula and salicylic acid, compressed absorbent cotton-wool wad, powdered with salicylic and boracic acids, tightly inserted. Hearing distance for watch proved to be  $\frac{1}{8}$ .

*September 11th.*—Cotton-wool wad, syringed well until thoroughly saturated and then carefully removed. This was followed by persistent oozing hemorrhage from the surface of the wound, which was checked by application of dilute Monsell's solution. Parts dried with cotton wool. Discharge less than before. Increased tendency to contraction of opening. Treatment as before.

*September 12th.*—Tampon removed in same manner as before. Slight hemorrhage. Opening smaller. Inserted an aural speculum, and by pressing steadily upon it for awhile dilated the opening. H. d. watch  $\frac{1}{8}$ . R. as before.

*September 13th.*—Tampon removed as before, and was found almost free of discharges. Opening only slightly smaller and edges somewhat "raw." Application, to these edges of dilute Monsell's solution, followed by profuse insufflation of boracic and salicylic acids (pulverized together) into canal and covering the entire surface of the wound. Tightly rolled cotton-wool tampon inserted as snugly as patient could endure it. This had been thoroughly covered with ac. bor. and salicyl., which was also rubbed into it.



Fig. 2.

*September 14th.*—No hemorrhage whatever on removing the wad after syringing it from the outside. Wad only slightly discolored by the discharges. The opening appears larger and more elliptical and the edge of the wound less moist and inflamed. H. d. watch  $\frac{1}{8}$ ; voice low at six feet.

*September 21st.*—From this time on the patient continued to improve and the case gave promise of speedy cure, when he began to report irregularly and at too long intervals, to drink again, and to neglect his surgical dressings. A section of a flexible red rubber Eustachian catheter (*See Cut II. left hand object*) was slightly coated with salicylated vaseline and tightly introduced. The patient was instructed to place a large piece of cotton wool over the concha and over this a bandage, on retiring. This he did the first night afterward, but carelessly neglected to do so on the second night, when the

rubber tube fell out of the canal during sleep. This, through his carelessness and neglect, was repeatedly lost, and was afterward replaced each time by me.

*October 1st.*—To-day the soft rubber tube was replaced by a hard rubber canula (*See Cut II. right hand object*). This canula was an elliptical cylinder with flange on upper, lower and posterior quadrants. Owing to the patient's carelessness, the plastic trages made for him was, ere this, lost by cicatricial contraction. It was intended to have it fill the space in front of the canula where the flange was wanting. This canula was secured by adhesive plaster, and a bandage, which the patient was permitted to remove in the daytime, with orders to readjust it on retiring at night.

*October 3d.*—Canula had come away, the patient having neglected to replace his bandage on retiring, as usual. The surface of meatus almost healed. M.t. clearing up; and after syringing the canal clean, the manubrium mallei and memb. flacc. were found congested. There has been no purulent otitis media, no sign of previous or present perforation of the memb. tympani. The discharge seems to have been generated from the walls of the canal.

From this time until October 22d, when last seen, the patient came very irregularly and at long intervals and did not wear canula and bandage as ordered. Over-drinking and neglect to refix bandage on retiring at night, resulted in his repeatedly losing the canula from the meatus.

*October 22d.*—H.d. normal for voice;  $\frac{1}{4}$  watch; loudly ticking clock heard at fifteen feet and further. No subjective symptoms. When last seen, on this date, he was dismissed with the canula neatly attached in place with adhesive plaster; being distinctly instructed that surgical aid had done its utmost for him, and that permanent recovery depended upon his own attention thereto and obedience of previous orders.

## SYPHILITIC INSANITY.

BY

D. F. KINNIER, M.D.

Ex-Lecturer on Diseases of Skin and Ear, College Physicians and Surgeons, Boston, Mass.  
Late Assistant in Dermatology to Dr. T. Colcott Fox, London, England.

**A**F—, æt thirty-five, is a native of the United States and has resided in this city for the past ten years. She was strong and healthy during her early life, having no illnesses except those commonly occurring in childhood. She contracted syphilis from her husband and now presents typical signs of that disease. She is in an excited condition and at present is obliged to be kept in bed by slight restraint and to be



quieted by sedative treatment. She has had miscarriages and two children born alive, who died when a few months old, with evident signs of congenital syphilis. She was confined some weeks ago of a living child, since which time signs of insanity have become noticeable, assuming the form of melancholia, with periodical attacks of excitement. Her tongue is swollen, densely coated, fissured and indented from pressure against the teeth, which are covered with sordes. She has typical mucous plaques on the tongue, and there exists a dry and parched condition of the buccal mucous membrane, with much faucial inflammation. The cervical and axillary glands are enlarged and her body is covered with a characteristic specific rash.

She has indolent ulcers on her hips, and lies in bed with her legs flexed upon her thighs, and, if moved, she screams as if in pain. There are signs of active inflammation in the knee joints, which are swollen, erythematous and very tender on slight pressure. Over the anterior surfaces of the tibiæ are well marked bullæ, variable in size, which are typical representations of the bullous syphiloderma. These bullæ are circular or oval in form, and distended, with a clear watery fluid, which later becomes cloudy and thick, owing to its admixture with pus and blood. The bullæ on becoming distended with fluid contents break and dry up, and thus give rise to scales and crusts of a yellow or greenish color. Beneath the crusts will be seen erosions of an ulcerous nature, with thickened raised borders and exuding a greenish yellow fluid. Her pulse varies from 100 to 130. There is marked syphilitic pyrexia, and her respirations are increased and labored, with turbulent action of the heart, which, upon auscultation, shows disease of the mitral valves. Her pupils are irregular. A consideration of her mental symptoms reveals the fact that she is troubled with hallucinations of sight and hearing; her speech is rambling and incoherent. She is mistaken in the identity of persons, and any footsteps she hears she imagines to be those of her acquaintances, and calls out their names. She developed delusions of conspiracy against her, and imagined that her body was polluted with a foul disease for which there is no remedy. She became dangerous to her children, and suffered from delusions of a depressing nature. She had periods of marked mental excitement with motor restlessness, passing into a delirious state, which, gradually diminishing, was followed by mild attacks of melancholia. She had several epileptic seizures, which were probably due to the specific disease having extended to the brain. Treatment being of

no avail, she gradually failed and died after a protracted illness. In the above narrated case, I consider that death was hastened by the syphilis having involved the brain structures. Her epileptic seizures I would attribute as due to syphilis, because upon the closest investigation I failed to obtain any evidence of the patient ever having had epilepsy or having been hereditarily predisposed to this morbid condition.

This disease having manifested itself at so late a period of life, and after she had contracted syphilis, I think there are sufficient grounds for supposing that her epileptic seizures were due to the extension of the specific poison to the cerebral tissues.

That brain syphilis exists, there can be no doubt, as this is one of the organs most frequently attacked by that disease. When syphilis does affect the brain, it has a special predilection for the dura mater, giving rise to gummatous masses between the layers of this membrane, which press inwardly on the brain substance, and externally on the internal tables of the skull.

Syphilis attacks the calvarium, especially the frontal bones, which becoming diseased, abscesses are developed, the contents of which form thrombi and occlude the cerebral vessels. Although syphilis frequently attacks the cerebral membranes it does not always confine itself to the dura mater, but includes in its course of destruction the basilar artery and those arteries which go to form this circle of Willis. In the case above alluded to, it was evident, judging from the symptoms, that there was syphilitic inflammation of the membranes, which set up arteritis and irritation in the vessels and contiguous parts of the brain tissue.

Fournier, Baumgarten, Friedlander, and other eminent syphilographers, who have made a special study of this subject of brain syphilis, assert that when syphilis attacks the brain vessels, it begins by affecting the intima or inner coat, and that the disease may extend through the intima by dissecting its layers and giving rise to aneurismal dilatations of the cerebral vessels. There is also produced a thickening of the intima inwards, which produces occlusion of the calibre of the vessels to which diseased condition Baumgarten gives the name of endarteritis proliferans. Friedlander, however, calls this condition of the arteries by the term endarteritis obliterans on account of the thickening or plugging up of the vessels by a thrombus. When syphilis attacks the base of

the brain, and the Fissure of Sylvius, symptoms of paralysis and aphasia are produced in proportion to the extent of the parts involved. These symptoms disappear as the patient recovers from the specific disease. The treatment adopted in this case was tonics, with mercury and iodide of potassium. The mercury when not given by the mouth was given by inunction or hypodermically. The inunction treatment was carried out faithfully, but did not seem to have the desired speedy effect wished for. The plan adopted was to take a piece of mercurial ointment, about the size of a pea, and rub it into the inside of the forearm, arms, chest, on the surface of the abdomen, on the thighs and legs, for about five minutes at a time. Thinking that a better result would be obtained by use of the hypodermic injections of mercury, that form of treatment was resorted to and produced a more ameliorating effect upon the disease for the time being. The form of mercury used was corrosive sublimate. In giving the injections I have prepared a solution containing one ounce of water and six grains of corrosive sublimate, and of this solution I begin by injecting five minims, or a sixteenth of a grain, and gradually increase the amount to one-eighth or tenth of a grain. Objections have been raised to this form of treatment on account of the injections producing pain, induration, inflammatory swellings and occasional abscesses. That these little difficulties are met with, is certain, but they may be guarded against by due caution. In beginning the treatment of syphilis by hypodermic medication it is important that a proper syringe be used. The kind I prefer are those made of glass, which the mercury will not corrode, which it does do if metal syringes are used. A short needle will not answer for these injections because the needle may not penetrate sufficiently deep into the integument, and hence the mercurial solution will not be taken up, since there are no absorbent vessels in the layer of the cuticle, and we need not be surprised if inflammation should set in. But this objection can be overcome by using a long needle and inserting it into the cellular tissue which is traversed by many absorbent vessels which readily take up the mercurial solution. In giving these injections I always begin with minute doses and gradually increase the amount to be injected until a full mercurial impression is obtained, and then care must be used to give only sufficient mercury to keep the system under a mild influence of the drug until the disease has disappeared. Great caution must be observed in treating syphilis by hypodermic injections of

mercury, and we should regulate the amount given according to the idiosyncrasies of the patient. The parts I usually select for giving injections are the lateral regions of the back, especially the infrascapular and sacral regions, as these are well supplied with subcutaneous cellular tissue, and rapid absorption takes place. My experience in the treatment of syphilis by this method is limited to a small number of cases, and the many objections which are raised against this mode of treatment have occurred to me, but by using great precaution with the syringe and always having it in a cleanly condition, I have overcome many of the objections and am much pleased with the results of this form of treatment.

Iodide of potassium was also given in gradually increasing doses, beginning with ten grains three times a day. This I consider to be the best method of giving this drug in syphilis of the nervous system. Iodide of potassium is quickly eliminated from the system, and hence the advisability of giving the drug in gradually increasing doses, so that the constitutional effects of the drug may be obtained. I prefer to give it after meals and largely diluted with water. When very large doses of iodide are to be taken, as, for instance, three or four drachms in twenty-four hours, I think it preferable to dissolve this amount in one-half-pint of water, and allow small draughts to be taken at frequent intervals during the day.

Taken in this way, I am satisfied that good effects will be obtained, and there will be less liability of disturbing the stomach than if large doses were taken.

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#### ON THE CLINICAL DIAGNOSIS OF LUPUS ERYTHEMATOSUS OF THE HAND AND FOOT.<sup>1</sup>

BY

HERMANN G. KLOTZ, M.D.,

Attending Physician, German Hospital and Dispensary, of New York.

(*Concluded from page 65.*)

**L**UPUS VULGARIS would next suggest itself to consideration. Rosenthal<sup>2</sup> contents himself with calling attention to the absence of the characteristic brown nodules (subcutaneous points of Duhring), and to the absence at all times of softening or ulceration of the tissues. These nodules or tubercles are indeed claimed without exception by all authors as the most pathognomonic symptom of lupus; they may, however, be

<sup>1</sup> Candidate's Thesis presented to the New York Dermatological Society.

<sup>2</sup> l. c.

temporarily absent, particularly in older patches, which form well defined plaques. Therefore, Auspitz rightly says<sup>1</sup> that "it is not sufficient to keep a case under observation for one or even three weeks," but during longer observation they are most likely to appear at some time, either detached from the patch or as recurrences in the cicatrized central portions; and where an elevated, wall-like border surrounds the patch, this will be found, on closer examination, to be composed of closely aggregated tubercles of this kind. Altogether, however, if so much weight is put on a symptom by all authors, its absence should certainly render the diagnosis of lupus at least highly improbable.

The absence of softening, disintegration or ulceration is not of so great importance, for it can hardly be denied that the so-called lupus exfoliations may run for a very extended period without ever exhibiting these degenerative processes. But it is not so much lupus in general that we have to consider, than certain species of that disease which may present great resemblance to my cases. Nobody would think of calling them lupus tuberculosus or exuberans or exedens, nor could lupus tumidus or hypertrophicus, or exuberans, or the elephantiasis-like form come into question, as all authors agree that these forms always proceed from previously ulcerated granulating surfaces. Nor is there an affinity to what Auspitz<sup>2</sup> describes as lupus sclerosus, and Neisser<sup>3</sup> cites as principally occurring on the extremities; a form accompanied by cedema, chronic lymphangitis and thickening of the subcutaneous connective tissue. But two other species deserve indeed special consideration, the lupus sclerosus of Vidal<sup>4</sup> and the lupus verrucosus of McCall Anderson,<sup>5</sup> cited by Duhring. After comparing the original of Vidal, I cannot understand how L. B. could confound this affection with the one present in Hyde's cases. Vidal speaks of a primitive and of a secondary sclerous lupus, the former developing from a small reddish or bluish elevated spot and extending into infiltrated patches, then forming uneven warty prominences with papillomatous, horny excrescences, separated by furrows and fissures. These fissures can terminate in real ulcerations, furnishing a sero-purulent fluid. They finally cicatrize, and within the scar the tubercles of lupus may again develop

<sup>1</sup> System, p. 167.

<sup>2</sup> System.

<sup>3</sup> Ziemssen I., p. 602.

<sup>4</sup> Annales de Dermatologie, etc., 1883, p. 414.

<sup>5</sup> Lectures on Clinical Medicine, London, 1879.

later on. It is apparent, that Vidal distinctly mentions the presence of the characteristic nodules of lupus, and the tendency to suppurate, features entirely absent in Hyde's cases. Still less similarity exists with the secondary form, which develops from a previous tuberculous lupus, and all the phases of transition from the original type to the sclerous one may be observed on the same individual. If the patches are squeezed between the fingers, matter can be seen to ooze from out of the depth. Vidal cites, that in Anderson's cases, after the removal of the papillary growths, small soft tubercles are seen to develop on the surface, and therefore claims the identity of Anderson's lupus verrucosus and his own "lupus sclereux." To judge from Duhring's citation, however, this suppuration, which we shall meet again as a distinct feature of another affection, to which I shall have to refer later on, is not essential to Anderson's form, which rather seems to be identical with the papillary lupus mentioned by several German authors, particularly by D'Outrelepond,<sup>1</sup> as occurring most frequently on the hands, and as being of a benign character. I cannot show better how these cases may be distinguished from cases of lupus erythematosus like my own than by briefly reporting a case which I was fortunate enough to observe but recently.

G. H—, seventeen years of age, born in the United States, of German parents, a brass finisher, applied for treatment at the dispensary on June 21, 1887. Family history unimportant; the patient himself is in good general health. About ten years ago the present disease began on the ulnar side of the back of the right wrist, where only a small white movable scar remains. Soon after it began to develop on the dorsal aspect of the web between the right thumb and index finger. When examined, a not well defined dark reddish patch of the size of a fifty-cent piece was found, near the border of which several small nodules, imbedded in the tissue of the cutis, could be seen and felt. On pressure, the reddish color did not entirely disappear, and the tubercles, as well as the borders of the patch, assumed a brownish tinge. The centre was covered with adherent crusts, after the removal of which an uneven surface of a papillary structure made its appearance. On the 15th of November, after continued application of the ten per cent. compound salicylated plaster, the patch presented a perfectly smooth, atrophic skin, except on a small portion of the size of a three-cent silver piece near the centre, which

<sup>1</sup> Monathefte f. prakt. Dermatologie IV. 1885, p. 351. Transactions of the Congress of German Surgeons in 1885; surgical observations on tuberculosis.

still allows of the recognizance of the papillary structure. The patch is covered with a thin epidermis, leaving only a few excoriations of the size of a pin's head. On the periphery, near the free border of the web, several small nodules can still be distinguished, which retain their brownish tinge on pressure. Here the characteristic primary efflorescences of lupus leave hardly any doubt of the nature of the affection, in spite of the absence of suppuration or ulceration, while at first sight the case did not differ much from my other cases. It confirms the assumption, that in lupus, as well as in lupus erythematosus, proliferation of the horny cells of the epidermis and papillary hypertrophy may take place, in the sense of the symptomatic papilloma of Hardaway.<sup>1</sup> Whether there exists by itself a true disease of papilloma of the skin in any other sense, is at least doubtful. That form, which has been described by Roser,<sup>2</sup> Weil,<sup>3</sup> and others, as *Inflammatory papilloma of the skin*, is not a chronic affection. Here, too, granulations more fungoid in character, developing from an ulcerated surface with continual suppuration in the fissures between the papillary growths, are the rule, the characteristic feature. the growing together of the papillæ with their tops, being particularly noticeable.

Inveterate squamous *eczema* may occasionally present some of the features met with in my cases, dry crusts, fissures and considerable infiltration, but not for any lengthy period. Sooner or later some other stage of *eczema*, either the vesicular or the pustular or that of *eczema madidans*, will prevail, either over the entire patch or over some portions of it; besides, the crusts will not project into the underlying tissue, but will often reveal a moist, weeping surface. Finally, itching would hardly be missed for any length of time.

*Psoriasis*, too, may form thick scales and crusts with fissures and large infiltrated patches; but the scales themselves are more soft, whitish and glistening; they can be removed quite easily, and expose a perfectly smooth, glossy, red surface, with oozing of minute, pin-point drops of blood.

Patches of the *tubercular syphilide* may exhibit an appearance quite similar to the patches of lupus erythematosus. Here, however, the border is not of a red color, but rather of a dirty, bluish tint; it will retain its color under pressure, or change it more into a brownish shade; the crusts will hardly

<sup>1</sup> Archives of Dermatol. Oct. 1880.

<sup>2</sup> Ans. d. Weilkunde, vii, 1886.

<sup>3</sup> Viertelj. p. Dermatologie, 1874, 1.

be found so dry and hard as in lupus erythematosus, but thicker, softer and more of a greenish color. Although ulceration does not take place regularly, in by far the greater number of cases small areas of softening and breaking down will occur. Quite often the crusts will conceal the ulcers until under the application of a plaster or ointment they will quickly become visible. The course of the syphilides is in general a more rapid one, and cicatrization results in very thin, parchment like, pliable scars. Not much reliance can be placed, in such cases, on the history given by the patients, nor on the absence on examination of other signs of syphilis, for scarcely in any other form of syphilis do the patients so frequently deny all knowledge of previous symptoms, and will even the most searching examination fail to reveal other manifestations of the disease.

There remains for consideration still another affection, to which I have already alluded on several occasions, the *tuberculosis verrucosa cutis*, described by Riehl and Paltauf<sup>1</sup> as a fourth species of tuberculosis of the skin and as a new, hitherto undescribed form of disease. It certainly does seem strange that the authors should have met, within a comparatively short time, with fourteen cases of a disease which had never been seen before, and, as must be assumed, did not previously exist. It would seem probable that similar cases were seen by other observers, but were classed among some of the already recognized species of disease. It would be easier, however, to compare Riehl and Paltauf's observations with similar cases, published by other authors, if the former had given detailed histories of their single cases, instead of a general delineation of their clinical features only. To judge from this description, there exists a great conformity with my own cases, particularly with the second one, and to a certain degree with Hyde's cases. There is the outer erythematous band, then follows a somewhat wider, more elevated, infiltrated zone, which pales under pressure with a yellowish tinge, while the centre is formed by a mass of warty growths, with club-shaped or pointed extremities, covered generally with crusts. They differ, however, by the presence just within the outer border of small lentil to hemp-seed sized, superficial disseminated pustules with thin crusts or scales, the remnants of the former, and by the existence of small erosions or pustules between the papillomata and warty excrescences, from which numerous drops of pus escape, when the patch is squeezed. This condition I have shown to have been

<sup>1</sup> Viertel j. f. Dermatol. 1886, p. 19.



observed in some of Vidal's and in other cases of lupus sclerosus, as well as in the inflammatory papilloma, while in my own cases, as well as in Hyde's, the strict absence of discharge or suppuration has repeatedly been insisted upon. Nevertheless, the occurrence of well-defined roundish patches, the tendency to peripheral spreading, the central depression in old patches, the absence of the brown nodules of lupus vulgaris, the formation of dry crusts on the surface, besides the coincidence in the age of the patients and the extremely slow progress made by the disease, might well remind you of lupus erythematosus. Strange enough, though, the authors, in considering the differential diagnosis, do not think of such a possibility, but simply say: "It is not necessary to enter into the differentiation from lupus erythematosus and lichen rubber, which occasionally are met with in similar shape in the same localities." They seem to have been entirely engrossed by the results of their microscopical examination.

The principal pathological conditions found in different pieces, taken from the patches, by Riehl and Paltauf, are: an unusual development of the horny layer of the epidermis, extending over the enlarged papillæ and in the interstices between the latter; the stratum lucidum and granulosum are not altered materially, but the layer of prickle cells shows increased development. In the cutis the principal alterations are limited to the superficial portions, the papillæ and their basis, the deeper portions participating only in a temporary and insignificant manner. The papillæ are enlarged in every dimension and of irregular shape; instead of the stratum vasculosum subpapillare, a series of isolated or irregularly confluent foci of embryonal cell infiltration are formed, which, as a rule, extend only in a horizontal direction, without reaching downwards into the region of the sweat glands. Around this infiltration the conditions of more or less developed chronic inflammatory changes are met with, viz.: considerable proliferation of cells and an increase in and dilatation of capillary blood vessels. So far the microscopical appearance answers very well to the description given of lupus erythematosus by Kaposi, Veiel, and others. The foci of infiltration, however, at least in some portions of the affected parts, were found by Riehl and Paltauf to exhibit all the qualities of giant-cell tubercles, in which by the usual methods of tinction the bacilli of tuberculosis could be demonstrated in much greater numbers than they are generally met with in lupus vulgaris. But to the great

surprise of the investigators, besides the conditions of cheesy degeneration, those of suppuration were found, together with numerous micrococci of various size and nature. There is no reason to doubt the correctness of the description given by Riehl and Paltauf, which is at variance with the conditions found in other cases of tuberculosis of the skin. Hence, the authors feel bound to establish a new disease. Among the fourteen cases which they observed, ten were found in males, four in females; owing to their occupation as butchers, farmers, coachmen, cooks and housewives, the patients were all brought into frequent and close contact with domestic animals directly, or with animal products. On the strength of this coincidence and of the histological conditions, after a review of our present knowledge of inoculation of tuberculosis, the authors conclude that the affection is a true inoculated tuberculosis of the skin. In this point I fully agree with them; but it seems to me, the question may be raised, whether the affection was an inoculated tuberculosis originally or whether the infection was a secondary one, through inoculation of tuberculosis into a previously existing pathological product of a different nature. The fact that simultaneously with the bacilli, micrococci, the propagators and unfailing companions of suppuration, were found, constitutes a point greatly in favor of the theory of secondary infection. After deduction of the conditions due to the double infection, clinically and histologically, the features of my cases would remain as the original condition of Riehl and Paltauf's cases, distinguished from Hyde's and other cases of lupus erythematosus of the hands only by the hypertrophy of the papillary layer. Assuming that in those cases there existed originally patches of lupus erythematosus, circumstances favoring the development of capillary hypertrophy as well as the infection with tubercular and septic material are furnished by the occupation of the patients, and we have an explanation for the production of the final condition of the diseased patches. If the exposure resulting of these occupations was sufficient to produce such an affection, without the previous existence of some other lesions of the skin, certainly they ought to be met with much more frequently, considering the great number of individuals engaged in similar occupations. With the acceptance of my explanation, which naturally is intended only as a suggestion, but which, with the certainly still somewhat primitive state of our knowledge of inoculation of tuberculosis and other infectious processes, does not seem irrational, the estab-

lishment of a new disease of the skin could be dispensed with. Perhaps in the future the further investigation of secondary infections and inoculations, and the study of their influence on previously existing pathological conditions of the skin, may shed some light on some obscure affections and help to simplify the nomenclature and classification of diseases of the skin.

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CIRCUMSCRIBED HYPERTRICHOSIS (ACQUIRED) IN THE LUMBAR REGION.—THE REPORT OF A CASE.

BY

A. H. OHMANN-DUMESNIL, A.M., M.D., of St. Louis.

**I**N 1885 I had the opportunity of observing a case which presented some points of interest. The following is a brief history, obtained from the patient at the time he presented himself:

Mr. G—, aged thirty, and following the occupation of a car conductor, is tall, of spare build and shows evidence of not being well nourished. He has a strong growth of hair in general, the color being a dark brown. He has a luxuriant growth on his head, his beard is strong, and he is well provided with hair upon the chest, in the axillæ and upon the pubes. He states that he has always enjoyed pretty fair health. When quite a boy he ran away from home and went to sea. At the age of sixteen he served on shipboard as an ordinary seaman. About this time, while engaged in his duties, he one day fell from the shrouds to the deck. He sustained but very slight injuries, being stunned more than anything else. He was, however, "laid up" (as he expressed it) for a few days. He was merely enjoined rest, no local application being made, and he was soon up and about attending to his work as usual. A little while after the occurrence of this accident, the exact length of time not being obtainable, he noticed the strange growth of hair shown in the accompanying Cut.

The site involved is located in the lumbar region, some little distance above the internatal cleft, and the area involved is about two inches by three and one-half. The hair which grows here is curly, of a nut-brown color, soft and silky in texture, quite fine and eight inches in length, at its longest part. The hairs are quite numerous, being almost as closely implanted next to each other as upon the scalp. No other portion of the body is affected in a similar manner.

The shape of the affected area is somewhat ovalish, the large axis of the oval lying horizontally across the trunk and extend-

ing on each side about an equal distance from the median line, or rather a little more to the left, as shown in the figure.

The patient states that he has never applied for any means whatever for the removal of the hair. As the hair grows inconvenient by reason of its length, he simply cuts it off with scissors. The extreme length to which it will grow has not been ascertained by him. He asserts, with how much truth I am unable to state, that he has had this growth three feet in length, hav-

ing deferred cutting it in order that he might see how long it would grow. It is hardly probable that this length was attained.

An interesting point in connection with this case is the location of the growth. It is not usual for acquired hypertrichosis to show itself in the lumbar region, in cases where no external applications have been made to the locality which is the subject of this excessive development of hair. And upon this point the patient is very positive—no external applications whatever

were ever made to the part implicated. When he met with his only accident, on board ship, the injury was so slight that only a small amount of rest was deemed necessary. He is equally positive that, at the time of this accident, there was no unusual growth of hair in the region which is implicated.

This naturally leads to a consideration of the cause of the hypertrichosis in this case. It was evidently not due to an injury to the nerves; for, in that case, the hair would in all probability have disappeared when the nerves again became normal, as I have had an opportunity to observe in a case. At present, the nerves are all in a normal condition, as also the brain and spinal cord, and, after a lapse of about twenty-two years, the hairs still remain. Evidently, we must look somewhere else for the cause. We cannot invoke the theory of local irritation due to exposure of the skin to the sun and air, as the affected part was protected from such influences.

One of the peculiarities in this case is the length to which the hair will grow if allowed to do so. As a rule, hairs upon the trunk do not attain the length of those in special localities, such as the face and scalp, although upon the chest and along the spine they may attain a length of several inches in some individuals. Sometimes a few isolated hairs around the nipples will grow to a length of six or seven inches, but they are few in number on the same subject.

Bartels has characterized the condition under consideration as "heteropy of trichosis," from the fact that there is a circumscribed hypertrichosis occurring on a portion of the integument, which otherwise is apparently unchanged. It is in the sacral and in the lumbar regions, the latter more often, that this form is found to occur. It sometimes happens that it will be complicated by a spina bifida, when present in the lumbar region. Dr. Paul Michelson (*Ziemssen's Handbook of Skin Diseases*) looks upon hypertrichosis in the unchanged skin as genetically equivalent to that on a thickened and pigmented skin.

To return to the pathogeny of hypertrichosis, we find that three principal cases are recognized, viz.: heredity, neurotic influences and cutaneous irritation. The case recorded above cannot be relegated to the first class, as the history shows that it was acquired. For this reason it is not, strictly speaking, heteropy of trichosis, as Bartels applied the term to those cases which are congenital. Neurotic influence could not be made out in the case; yet it is not beyond the range of possibility that the patient, in falling to the deck, had his spinal cord suf-

ficiently disturbed to produce the condition necessary to account for the growth of hair. On the other hand, it seems but natural to conclude that the hair should have disappeared when the accident causing its presence had left. The third possible cause had already been disposed of, and we still remain without any adequate or satisfactory cause to explain the condition. The etiological factor is obscure, in general, in cases of hypertrichosis, and it is, at best, quite a difficult matter to determine the cause in a large number of cases.

In conclusion, I wish to state that the relative amount of hair, and the area of the surface involved, have been constant, according to the statement of the patient. There has been no change in the condition since he first observed it. He has persistently refused to have the hairs permanently removed, preferring to cut them off from time to time, and thus avoid what he thinks would prove a terrible ordeal.

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## Society Transactions.

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### THE NEW YORK DERMATOLOGICAL SOCIETY.

#### THE 178TH REGULAR MEETING.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. CUTLER presented a

#### CASE FOR DIAGNOSIS.

The patient presented on both legs densely infiltrated, elevated and sharply circumscribed patches, which had been present fourteen years. There were also discrete separate small papules here and there, over legs and thighs, and a few patches of squamous eczema.

DR. ROBINSON, in opening the discussion, said that he thought the case was either one of lichen planus or that the symptoms were the results of a precedent eczema constituting the so-called *eczema verrucosum*. In favor of lichen planus there were the strict limitation, the long duration, the scaly appearance of the lesions and the small discrete papules. Against that disease was the papillomatous character of the patches, and their remaining that size for so long a time. The discrete papules also did not resemble those of lichen planus, but were perifollicular. He had also detected the presence of a few vesicles and evidences of serous exudation, features not present in lichen planus. Besides its situation in the flexures, the history of the patient having had an eczema, the general thickening of skin above the knee, and the warty condition of the lesions, would cause him to regard the patches as the result of an eczema which had become papillomatous, and which might persist unchanged for many years.

DR. KLOTZ regarded the case as one of lichen planus owing to the circumscribed form of the patches and their limitation to only a small part of the body.

DR. SHERWELL doubted if any exact diagnosis of so persistent an eruption was possible. He had not seen any of the vesicles mentioned by Dr. Robinson, and though inclined to call the case one of lichen planus, yet did not wish to make a positive diagnosis.

DR. ALLEN thought it was lichen planus. Some patches on thigh looked like eczema, but he had not seen any vesicles.

DR. ELLIOT regarded the lesions as those of lichen planus. They agreed with that disease in color and general characteristics. The eczema which was present, he thought could have been produced by the scratching consequent upon the itching, and could scarcely be brought into account in explanation of lesions which had been present for fourteen years.

DR. TAYLOR considered the disease a sequel of an eczema, an eczema verrucosum.

DR. CUTLER, in summing up, said that he had presented the case as one of lichen planus, but yet it resembled so much eczema that a question of diagnosis had been raised. He had had an eczema for the past year, which had yielded to treatment, but these spots had remained unchanged. He thought the color of the patches was more suggestive of lichen planus than of eczema. By daylight the discrete papules were most distinct, and covered with little scales unlike the squamæ seen in eczema.

DR. CUTLER presented a case of

#### ERUPTION IN A NEGRO.

The affection was presented on the face and forehead, and also upon the fore-arms.

DR. MORROW regarded the case as eczema erythematosum. The color of the negro obscured the ordinary characteristics of skin diseases, but he thought that in this case the clinical behavior of the eruption, its limitation to hands, face and neck, the itching of the parts and the pruritus about the genitals, established the diagnosis. The great amount of pigment on those surfaces was an evidence of a long-continued congestion.

DR. SHERWOOD regarded the case as one of eczema erythematosum. The interesting feature in his mind was that that form of the disease was invariably closely connected with a rheumatic diathesis. This patient gave history of having had rheumatism.

DR. CUTLER thought that it was peculiar that there should be so much pigmentation, the eruption having been present only two months. He called attention to the similarity between the patches on the arms of this patient and on the legs of the previous one shown.

DR. MORROW presented for Dr. Fox a case of

#### MILIARY PAPULAR SYPHILIS,

which on the arms and on other portions of the body bore a very marked resemblance to a psoriasis. On the body were grouped miliary papules, but on the extremities these had coalesced, forming diffuse patches. There was a large amount of scaliness.

DR. CUTLER said that he thought it might be a small papular syphilide in a man subject to psoriasis. He had seen cases of miliary syphilis modified by that fact.

DR. MORROW stated that it was a question whether lesions having a marked resemblance to psoriasis could be said to have been modified by the existence of the psoriatic diathesis. He thought that the modification would depend rather upon some peculiarity of the skin of the individual.

DR. TAYLOR said that the excessive scaling was due to the chronicity of the eruption. The lesions are perifollicular, and cause atrophy, due to their profundity and obstinacy.

DR. ELLIOT presented for Dr. Bronson a case of

ERUPTION UPON THE HANDS AND FINGERS.

The patient is a man forty years of age, a policeman, who is suffering from a vesico-pustular eruption on the hands. Some of the lesions occurred about the nails, and had the appearance of an ordinary "run-around." Other deeper-seated vesicles, or vesiculo-pustules, were scattered over the fingers and palms to the number of five or six on each hand. They were attended with considerable throbbing pain, and had first appeared about three weeks before.

DR. MORROW thought that in its etiology this case was a puzzling one. He had seen vesicles and pustules on the hands and fingers determined by contact with various irritating substances. For instance, he had observed similar lesions on the hands of those engaged in the manufacture of green paper boxes, evidently produced by the contained arsenic, and in one or two cases he had seen such an eruption caused by gloves, colored by bichromate of potassium. In this case it seemed that no such irritant cause could be alleged, and for that reason he thought it was obscure.

DR. KEYES said that he remembered several of such cases in which shedding of the nails followed suppuration. It had always occurred in young children and in strumous subjects. He had never seen it in adults except when caused by irritants.

DR. KLOTZ stated that he considered the lesions as due to septic infection. Every one was exposed to the poison which could produce them. He called attention to the frequency of little wounds around the nails which could serve as points of entrance for the poison.

DR. SHERWELL thought it was from local irritation. He had seen the same result from arsenic, and recalled cases which occurred on men who had been engaged in unloading bags of the poison. One of the bags burst, and those with whom the arsenic came in contact suffered from a pustular dermatitis.

DR. ALLEN said that he had seen, four or five years ago, a number of cases of arsenical dermatitis, which had occurred on longshoremen engaged in unloading hides. In these cases both the hands and feet were affected. He had heard that the arsenic in the tickets on the elevated roads had also produced similar affections, but had not been able to prove this by investigation.

DR. ELLIOT regarded the case as one of local septic dermatitis. He saw perhaps from six to ten such cases every week, and by simple antiseptic treatment they disappeared rapidly. He thought that the intimate connection between pus and micro-organisms had been so abundantly proven that these cases of dermatitis pustulosa should scarcely need any further explanation than that of local infection. Every one was exposed to it, and, the micrococci of pus obtaining ingress through some small wound, the result would be lesions similar to those presented by Dr. Bronson's case. The presence of the lesions on the fingers and hands, portions most likely to be exposed, would also favor this view, and he did not think that the case could be regarded as anything else but a local infection.

DR. BRONSON, in summing up, said that as far as he knew, there had not been any local irritation. He did not think that sepsis could explain it. The man was robust, there had been no fever or any evidences of septicaemia. It resembled a "run around" which occurred in children especially, but yet he thought from its herpetic character that it was neuritic in nature.

DR. ELLIOT said that when he called it septic dermatitis he did not mean septicaemia, but only local sepsis. A local septic process was a well recognized condition, and one which did not postulate general sepsis, but only



infection in one localized spot. As far as the lesion "run around" was concerned, it had also been found to be produced by a special micro-organism.

DR. SHERWELL presented a case of

PSORIASIS

in a child aged six and a quarter years. The eruption appeared for the first time in August, 1887, on the head and neck, and very extensively over the limbs, at least one-third of the skin of the latter being affected. The case was shown as exemplifying an extent of eruption unusual in one so young. The case was doing extremely well with ungt. chrysarobin and acidum salicylicum.

DR. TAYLOR stated that he could recall a child three years old who had psoriasis and whom he had seen with Dr. Draper a number of years ago.

DR. ELLIOT said that some time ago he had reported (*Med. Rec.*, July 1886) a case of the disease which had begun at the age of thirteen months. When he saw the child it was eighteen months of age, and the lesions were numerous, not only over the head, body and extremities, but also were present on the palms and soles.

DR. ALLEN then read the history and clinical description of a case of

PEMPHIGUS ACUTUS SEU FEBRILIS.<sup>1</sup>

DR. BRONSON reported on the case of "Eruption on the Nose," which he had presented at the last meeting of the Society. He said that the treatment had favored the diagnosis of lupus erythematosus. Mixed treatment had been given internally and ungt. hydrargyrum applied externally, but without any benefit. He had then treated one side with pure carbolic acid and the other with scarification. Immediate and marked improvement followed.

DR. ELLIOT stated that he had made microscopical examination of portions of tissue removed from the border of the "Ulceration on Scalp" presented by Dr. Lewis at the last meeting of the Society. He had found the disease to be sarcoma. The portion on the forehead, which had been pointed out as morphea, was also found to show sarcomatous tissue.

DR. ALLEN spoke of the case, which he had shown to the Society, of enlargement around the urethra, and which some of the members had thought was a peri-urethral abscess. He had considered it to be a gumma, and had observed its complete disappearance under proper treatment. Since then a gumma has appeared on arm of patient.

DR. TAYLOR stated that stricture sometimes resulted from the absorption of a gumma situated in the corpus spongiosum.

The Society then went into Executive Session.

## Correspondence.

### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

On the Surgical Treatment of Skin Diseases at the St. Louis Hospital in Paris, and in particular the method of Quadrilateral Linear Scarification.

DURING his stay in Paris, which has left us such agreeable recollections, the Editor of this JOURNAL asked me to place before the readers of the journal the noteworthy methods of treatment by quadrilateral linear scarifi-

<sup>1</sup> Will be published in April number.

cations which Dr. Vidal has employed for more than ten years in his service at the St. Louis Hospital. I now keep my promise.

#### **Methods of Linear Scarification anterior to those of Dr. Vidal.**

Dr. Vidal has had some predecessors in this line, and we may cite among them Angello Dubini, of Milan, who practiced punctures in lupus tissue, to facilitate the penetration of the ointment of the biniodide of mercury. Veiel also made punctured scarifications as close to each other as possible, so as to penetrate to the bottom of lupus neoplasms, and to lacerate the tissues and induce mortification, and to sever the majority of the vessels which nourish them. After this operation he covered the parts with a mixture of equal quantities of chloride of zinc and alcohol.

Volkman (of Halle) first scraped and abraded lupus neoplasms with large curettes, and three or four days after, when cicatrization began to take place, he made a large number of pricks with a straight bladed knife very close to each other.

Balmanno Squire (of London), after having attempted to practice scraping of lupus surfaces with curettes of smaller dimensions than those of Volkman, became satisfied with scarification of the diseased parts with a double bladed, lozenge shaped pointed knife or needle; these scarifications were parallel and at two millimeters distance from each other.

Two or three days after the first operation he made new cuts at right angles to the first, or obliquely across them. Like Veiel, he cauterized the scarified surface with a solution of chloride of zinc in alcohol.

#### **Method of General Linear Quadrilateral Scarifications.**

All the preceding attempts, and especially those of Balmanno Squire, are most interesting, but we must recognize the fact that the honor of having found the true procedure, and the one really practical and efficacious, belongs to Dr. E. Vidal. He also deserves the credit of pointing out the modifications necessary in the procedure according to the nature of the case, and of having generalized the method and made it applicable to the treatment of a variety of cutaneous affections other than lupus. His first researches in this direction date back to 1874, and are contemporary with those of Balmanno Squire.

*Instrument.*—The instrument which Dr. Vidal at present uses in making his scarifications has undergone many modifications, until now a model which seems to be perfect is manufactured by Dubois in Paris. It consists of a small flattened steel blade twenty to twenty-five millimeters (2 to 2½ centimeters) long, and about two millimeters wide. At about a centimeter from the point, this blade presents two cutting edges, exactly symmetrical at either border, separated from each other in the median line of the blade by a delicate and slightly marked projection. The triangular point from one and a half to two millimeters in length is only the prolongation of the two preceding surfaces. It also has two cutting edges which grow gradually thinner to the extremity (an angle of 55°). This blade is mounted in a square handle eleven centimeters long, slightly bulging in the central portion, where it is about five millimeters wide. It is seen that such an instrument would be most easily managed, and that in experienced hands it can be used to puncture, cut and lacerate in every direction, and as deeply as is desired.

*Manner of using.*—To make scarifications with this instrument, which

bears the name of Vidal's Scarifier, it is delicately held like a writing pen, without force but firmly, without pressing it between the fingers. This is usually directly obliquely to the surface of the skin to facilitate its penetration; but the incisions must always be made perpendicular to the surface, that is to say, the incision produced should be vertical and not oblique in reference to the surface of the integuments. When the first incisions have been finished, a second or a third series is made parallel to the first, and so on, then the first series of rectilinear lines is crossed by other rectangular incisions placed at the same distance from each other as the first, and ordinarily oblique in reference to them, thus forming with them angles varying from  $30^{\circ}$  to  $60^{\circ}$ , the average angle being  $45^{\circ}$ . This second series of incisions can themselves be obliquely crossed in lupus by a third or fourth series. The depth to which the instrument should penetrate, the distance which should separate the incisions from each other, and the length of the incision, are points which vary according to the nature of the affection, and according to the particular case.

### Hemorrhage—Subsequent Care.

It is easily understood that consecutive hemorrhage should result from these incisions, should vary with their depth, number and location, and with the subject operated upon. Ordinarily, the first operations cause a loss of blood much more considerable than the subsequent ones, and this is easily understood, since little by little the small vessels of the region are divided in all directions and become obliterated. Whatever hemorrhage takes place from these operations it never becomes dangerous, and is always quite easily arrested by applying over the scarified region an ordinary tampon of simple or absorbent cotton, or of cotton rendered antiseptic by corrosive chloride or salicylic acid. The flow of blood is thus arrested almost instantaneously, but should it not be, compression over the cotton for a few minutes will suffice. It must be further understood that no matter how deep the incisions must be carried to be effectual, there is a rule, which for my part I consider absolute or nearly absolute, that they should never or almost never divide the derma in its whole thickness, for in this case vicious scars would result. We see, then, that it is impossible in applying this principle ever to have very serious hemorrhage, since we are but rarely likely to divide the large vessels (veins and arteries) of the hypoderm.

If, however, in an exceptional case, the bleeding should continue in a given point, we may touch it either with the point of a nitrate of silver stick, or with the fine point of electric wire at a dull red heat. Subsequent dressings are of the most simple nature, and usually permit the patient to return at once to his ordinary occupation. The dressing varies according to the nature of the affection, and we will indicate it in speaking of each one separately. Often it is only necessary to apply, morning and night, a slightly antiseptic wash, such as a weak solution of boracic acid, corrosive sublimate or phenic acid. The incisions thus carried out generally heal with the greatest rapidity; ordinarily by the end of the third or fifth day cicatrization is complete, and it is possible to repeat the operation six or seven days after the preceding one. Dr. Vidal repeats his operations regularly every week, with an interval of eight days.

*Local anesthesia*—These operations are painful to a greater or less degree according to the region. The most painful localities are, first of all,

the upper lip and all parts of the end of the nose, the eyelids, the under part of the chin and the neck. It is not necessary to put the patient to sleep with chloroform or ether, but local anæsthesia may be practiced by freezing the part to be operated upon.

Dr. Vidal has for a long time employed for this purpose a spray of anæsthetic ether, or Richardson's mixture, used in England under the name of Compound Anæsthetic Ether. He prefers it to the pure ether and to the bromide of ethyl. He has noticed that by putting a few bits of cotton near the point against which the spray jet is directed, that the congelation takes place much more rapidly. For the past few weeks he has used a new method, due Dr. Bailly (of Chambly, France). This ingenious practitioner has found a means of keeping the chloride of methyl in a liquid state, by preserving it in a tube of glass, surrounded by another larger glass tube; a vacuum is produced in the interval, separating the two tubes, and the evaporation in the receptacle is thus reduced to a minimum. To use this agent, a small quantity is poured upon a tampon of dry cotton (non-absorbent), covered with oiled silk and held against the part with hard rubber, or other non-conducting forceps.

The tampon thus prepared, if moistened, with the chloride of methyl, at a temperature ranging from  $20^{\circ}$  to  $55^{\circ}$  below zero, remains active for a period ranging from 15 to 45 minutes. It is only sufficient to apply it to the part to be operated upon for a few seconds, to observe the tissues whiten and congeal. The anæsthesia, or rather the congelation of the skin, will be produced to a greater or less depth and more or less completely, according to the length of time that the tampon is left on. This process of refrigeration is an entirely practicable one. The operator has by his side the tampon already prepared with the chloride of methyl; he applies it to the part he desires to scarify, removes it quickly, practices the scarification, renews the applications to the neighboring region, and so on. Anæsthesia may equally well be effected upon the bleeding surfaces by this method, if a piece of gold-beater's skin be interposed between the bleeding surface and the tampon. The operation then becomes a rapid and painless one. Local anæsthesia even practiced by the new process which I have just described, and which both Vidal and Besnier already employ regularly in their service, presents, however, some real inconveniences. The operator no longer sees clearly the diseased points which he desires to touch, for the diseased parts, as well as the healthy tissue, have all become white. He is no longer guided by the resistance to the knife, so marked between the diseased and healthy parts, for now all are the same, the operation is consequently not so well done when local anæsthesia is used. When ether is employed, as soon as the circulation begins again the patient experiences severe pain and the blood flows freely. It seems that with the chloride of methyl the consecutive reaction is less painful.

The subcutaneous injections of chloro-hydrate of cocaine, practiced at intervals of two centimeters in the part to be operated upon, does not present the same inconveniences. I have been able to use it in some cases, and in one patient in particular, a very nervous and impressionable man of thirty-eight years, with acneiform lupus of the right cheek, chin and upper lip. I was not yet acquainted with the practical use of the chloride of methyl, and ether could not be borne. I made four or five injections of cocaine in the upper lip, introducing under the skin about seven or eight milligrams of the salt at each puncture. Five minutes later the sensibility

of the part was so blunted that I proceeded with the operation without the least inconvenience, the patient scarcely suffering at all. Some slight symptoms of general intoxication followed. It is true that in another patient I observed a true case of acute poisoning following a subcutaneous injection of two centigrams of the salt. Local anæsthesia, by injections of cocaine, offers the great advantage of neither modifying the natural color of the parts nor the consistence of the tissues. It permits as exact an operation as though the integuments were not painless, but it has the rather serious inconvenience of giving rise at times to symptoms of general intoxication. When the patients are cowardly or when the operations are really too painful, it is well, at times even necessary, to have recourse to local anæsthesia, but I persist in believing, that in spite of the recent perfections, it is preferable for the operator and for the regularity of the operation, not to employ it when it is possible to dispense with it.

#### Treatment of Lupus by Scarification.

It is especially in the treatment of lupus that linear quadrilateral scarifications have been applied, and they have given, in the hands of Dr. Vidal, in this disease, results which have really been surprising. We will not occupy ourselves here with the many theoretical questions that might be raised in regard to lupus, but will content ourselves to recall to our readers in America, that, according to the views of Dr. Besnier and Vidal, the group "lupus" comprises two great varieties: First, *Tuberculous lupus*, accepted as a lupus, or a variety of tuberculosis of the skin by all the schools; and, second, *Erythematous lupus*, which these two authors place in the same morbid group as the former, and which many dermatologists regard as a distinct affection. Both varieties justify scarification.

#### Tuberculous Lupus.

Whatever may be the form of tuberculous lupus that we have to treat, two principal rules govern the treatment: First, always to go to the limits of the disease in depth, and reach, with the point of the scarifier, solid, healthy tissue, for otherwise we would leave intact the deeper parts of neoplasm, and recurrences, starting from the deep parts, would be constant and disastrous. Second, to arrest, first of all, the invading march of the disease upon the surface, and for this, we must pass with the scarification beyond the apparent limits of the lupus infiltration several millimeters, for the vessels of the periphery are dilated and diseased, around them a proliferation of embryonic cells has taken place, and this proliferation must be attacked and destroyed, under penalty of seeing the disease progress. We must not fear to make incisions into the healthy skin, for, provided that they do not invade the whole thickness of the skin, they will not leave cicatrices. This rule, to attack first of all the whole periphery of a lupus of extensive advance, by acting upon the healthy tissues, is of so great importance that, in cases of extensive lupus, Dr. Vidal is satisfied with treating the borders of the patch alone.

The scarifications must be made as closely together as possible, but the true rule of conduct is to cut up the neoplasm in all directions to lacerate the tissues, and to penetrate to the base of the tubercular deposit, but on the other hand to spare, in a degree, the tissues relatively healthy which are found enclosed in the neoplasm. When one has acquired a certain dexterity

in these operations, all of these details become easy. Guided by the differences of resistance of the tissues, the instrument, held without rigidity, is forced into the tubercles, and, turned in all directions, lacerates the morbid products.

#### **Lupus Vorax.**

It is especially when we have to do with lupus vorax that we must not fear to produce too much damage. Nothing is comparable to scarifications to arrest the extensive march of this affection; but we must, first of all, reach the limits of the disease, that is to say, the instrument must be plunged into the morbid tissue up to a point at which a sensation of resistance is experienced; in other words, until we have reached healthy tissue. It is necessary to hack the tissues up in all directions, to cross and recross those incisions in such a way as to reduce to a pulp all the morbid tissues, which care is taken to leave in place and not remove. The patch is to be touched with a tampon of cotton wet with the perchloride of iron. Cicatrization takes place with the greatest rapidity, and five or six days later it is possible to begin over again. Ordinarily, it suffices to make from two to four such operations to arrest the progress of an extensive lupus vorax.

Ulcerating tuberculous lupus, and lupus tuberculosus non-exedens are to be treated according to the rules already given.

#### **Lupus with Isolated Tubercles.**

After a certain number of scarifications, the tissues are seen to shrink, to become more firm and bleached, and we come to what Dr. Vidal has called *the period of improvement*. In the cicatricial tissue of new formation, little yellow points are noticed, as large as the head of a pin or at times so small that the surface must be made wet to allow of their being seen. These are so many lupus tubercles all ready to bud, which must be attacked at once. For this purpose the needle is plunged into their interior as deep as necessary to reach the healthy tissue, and they are broken down in all directions one by one. The same treatment is extended to lupus characterized from the first by isolated tubercles. It is at times appropriate, after having thus attacked each tubercle, to make in addition over the whole surface a series of quadrilateral linear incisions. It should be stated, moreover, that the more we scarify a cicatrix of lupus in following the rules already laid down, the more we benefit it, the skin becomes whiter, more supple and more smooth.

*Consecutive care.*—As soon as the hemorrhage is arrested, Dr. Vidal sprays upon the operated region a solution of corrosive sublimate (1 to 1,000).

The patients then go home without any dressing. This treatment does not necessitate remaining in hospital. The lupus patients can go about their usual vocations as soon as the operation is finished. It is well, upon the evening of the operation, to wash the parts scarified with a solution of corrosive chloride (1-2,000), and the following day cover over the region with some Vigo's Mercurial Plaster. This plaster should be kept constantly applied, changing it morning and night, and washing each time with a sublimate solution. If the inflammation produced by this plaster is too strong, it should only be applied at night, and during the day a little oxide of zinc or boracic acid ointment should be kept on. There are some patients who can not tolerate this dressing, and in such case the vigo plaster is replaced by a plaster, for which Dr. Vidal has given the formula, and which is well known at the St. Louis under the name of red plaster. It is composed of two and a

half parts of minium, and one part and a-half of cinnibar to twenty-six parts of diachylon plaster. It is much less irritating than the vigo plaster. Finally, when deep ulcerations are produced, they are to be dressed dry with iodoform or iodol. A few hours before the next operation it is well to cease the use of the plaster to avoid too great irritation of the diseased parts which would render the operation painful and difficult if not impossible. It is equally necessary that the surfaces to be scarified should be completely freed from particles of plaster which adhere when it is removed—and for this it is only necessary to rub the surface with some simple grate or fresh butter.

#### Lupus of the Mucous Membranes.

Scarification also gives good results in the treatment of lupus of the mucous membranes. That which has appeared to be the most surely and the most rapidly benefited by this method is lupus of the conjunctiva. When the neoplasm has invaded the gums, the vault of the palate or the soft palate, scarification may be employed with success, but it appears to give less prompt results than the electro-cautery. As to lupus of the nostrils, it is here especially justifiable to employ scraping with the sharp curette, followed by cauterization, either with the nitrate of silver or the perchloride of iron, and finally washing with weak solutions of corrosive sublimate or boracic acid, applying insufflations of powdered iodol and an ointment composed of the yellow oxide of mercury, yellow precipitate, each one part, and vaseline, ten parts.

*Results obtained.*—As Dr. Vidal has demonstrated during the past eight years, the advantage of this method is that in skillful hands it produces an almost perfect cicatrix, while in scraping, the use of the thermo-cautery and electro-cauterization, and especially with caustics, depressions, loss of substance, cicatricial bands, irreparable deformities are produced, while, with scarification when a cure is obtained, the region which has been attacked can scarcely be distinguished. The skin regains its normal suppleness, its form, and often its color. As long as a bright redness persists, toward the borders of the neoplasm, we must fear that the cure is only apparent. This symptom usually shows that the morbid process is not at an end, and we must continue the scarifications methodically until it has disappeared. The patients should present themselves for examination every two or three months, to keep under observation and prevent recurrences by having all small tubercles which might appear in the cicatrix destroyed at once.

*The period of observation* should last at least a year. The number of sittings necessary for a cure of a tuberculous lupus is very variable according to the patient, and the extent and nature of the lupus; some get well in a few weeks, others resist treatment indefinitely. Of all forms of lupus it is probably the most severe, namely, lupus vorax, which is the most readily cured by this method.

We must not, however, believe that Dr. Vidal always employs this procedure systematically, and to the exclusion of all others in the treatment of tuberculous lupus. When the affection persists for a long time and there is no great tendency on the part of the patient towards the formation of keloidal scars, he at times, also, resorts to the actual cautery. I have shown, in a memorial published in 1886, that in using it with prudence and alternating with scarifications in rebellious cases, we can considerably decrease the time of treatment in this way.

In my next letter I shall speak of lupus erythematosus, erythematous acneiform lupus, and the other affections which may be treated by this method.

PARIS.

L. BROcq.

## DERMATOLOGY AND KINDRED STUDIES IN GERMANY.

### The Treatment of the Catarrhal Contracted Bladder by Cocaine.

M. HOROVITZ, in *Wiener Med. Wochensch.*, 1887, No. 32.—Whenever the bladder is forced to contract frequently and very vigorously, as in urethral stenosis, vesical tumors, calculi and catarrh of the bladder, its walls become so thick and inelastic as to lead to reduction in its lumen. The bladder undergoes concentric hypertrophy. Such an organ can retain only a very small quantity of urine, so that patients may have to urinate twice every hour. This condition is associated with more or less violent catarrh and scalding during micturition. The diagnosis is rendered certain by the facts that the urine is turbid, and that a sound introduced into the bladder is restricted in its movements, while the antero-posterior diameter of the organ is very much shortened. As regards the treatment of the catarrhal contracted bladder, it was formerly customary to introduce by catheter and syringe as much lukewarm water into the organ as the patient could bear until the bladder was able to retain a larger quantity of urine. This method, however, could be carried out only very slowly and with many interruptions, since the patients suffered sometimes violent pains, or their catarrh was aggravated, or profuse hemorrhages ensued. Horovitz, therefore, attempted to distend the bladder by injecting a sufficiently strong solution of cocaine, thus rendering the mucous membrane anæsthetic, and making the urine flowing into the organ the means of effecting the purpose. The bladder possessing only a minimal power of absorption, intoxication can hardly occur even after injecting as much as eight grains of cocaine hydrochlorate and keeping the organ anæsthetic for two hours. The result has been remarkably good, the bladder being satisfactorily distended.

### The Curative Effect of Erysipelas in some Forms of Disease.

E. SCHWIMMER, in *Oesterr. Med. Chir. Presse*, 1887, No. 37.—The general syphilitic diathesis (constitutional syphilis) remains entirely uninfluenced by erysipelas, as may be seen from the relapses of syphilis after the erysipelas has run its course; but the local process of the various syphilitic products heals very quickly. The local manifestations of lupus likewise remain uninfluenced, the alterations characteristic of the disease and the several nodules suffering no change. In a very prominent cicatricial keloid after a burn, a quite rapid absorption of the cicatricial tissue ensued, leaving the surface almost smooth. Also in a chronic bilateral epididymitis and orchitis recovery followed after an attack of erysipelas lasting ten days.

### Erysipeloid.

ROSENBAch, in *Arch. f. klin. Chirurgie*, 1887, No. 2.—Erysipeloid is a wound infection practically of little importance, but having a very noteworthy etiology. The infectious material is to be found in decaying animal substances, and, therefore, the cause of the disease is generally transferred to parts devoid of epidermis by the fingers during the handling of such bodies.



There arise at the infected points circumscribed bluish-red spots, slowly increasing in size and causing a sensation of moderate burning; they disappear after two or three weeks without leaving a trace. The general health and the bodily temperature remain unchanged. An erysipeloid derivable from rotten cheese showed that gelatin is the best culture medium for the schizomycetes, which are rather long lived and in their initial stage appear in the form of cocci. These apparent cocci constitute merely the developmental forms (spores) of a long filiform, felted fungus provided with false anastomoses. At the ends of the threads may often be seen bent off parts studded with thick points, which are interpreted as ultimate spores. Four days after inoculation the gelatin cultures, growing at 20° C., become visible. It is not unlikely that Rosenbach was dealing with threads of *Cladothrix*.

#### On the Mechanical Treatment of Syphilitic Psoriasis Mucosæ Oris.

HOROVITZ, in *Wiener Med. Presse*, 1887, No. 42.—Psoriasis mucosæ oris of syphilitic persons is one of the lasting products of lues which does not yield to any specific treatment; it cannot be placed in the same category with mucous patches which appear in the early period. This affection produces a profound alteration of the cell nuclei of the deepest epithelial layers. Thickening of the epithelium at some points, and defective development at others, is the characteristic mark in the growth of this epithelial anomaly. The treatment must endeavor to reduce the greatly thickened callous spots to a normal degree and stimulate the parts denuded of epithelium to the formation of skin. Horovitz found the remedy in the use of the sharp spoon. The epithelial masses are scraped off down to the papillary layer; slight hemorrhage indicates when it is reached. The spots thus treated are then penciled with a ten per cent. solution of silver nitrate; the pain of this operation being prevented by the previous application of a ten per cent. solution of cocaine.

#### Contribution to the Question as to the Treatment of Syphilis by Calomel Injections.

E. WELANDER, in *Vierteljahrschr. f. Dermat. u. Syphilis*, 4 Heft, 2 Hälfte.—In general, Welander confirms the results published up to the present time regarding calomel injections in syphilis. The advantage of the method consists in the small number of injections required, and in their lasting effect. The disadvantages lie in the formation of painful infiltrations and abscesses, in the unequally rapid absorption of the mercury in some patients, and in the uncertainty of dosage, since a part of the insoluble mercurial salt remains in the syringe, and another part in the vessel as a precipitate. This agent protects against relapses as little as any other, no matter in what form employed; nor can it prevent the outbreak of syphilis, if used prophylactically before the appearance of general symptoms.

#### The Treatment of Syphilis with Hydrargyri Oxidum Flavum.

O. ROSENTHAL, in *Vierteljahrschr. f. Dermat. u. Syphilis*, 1887, 4 Heft, 2 Hälfte.—The drug was suspended in the following form:

℞ Hydrargyri oxidi flavi..... gr. viij.  
Olei amygdal. (sive olei oliv.)..... ℥. ss.

and injected vertically into the musculature of the gluteal region, by means of a syringe having a capacity of two grams and provided with a long needle. According to requirements, one-half to two-thirds of the contents of the

syringe were used. The place of injection was invariably cleaned beforehand, the air bubbles were expelled from the syringe, the disinfected needle was dipped into oil before insertion. Altogether, from three to five injections were given in each case. Rosenthal has never observed abscesses, though he has seen infiltrations which were less painful than those after calomel. With this method, too, the dosage is not quite scientific, being undeterminable. Next to the inunction treatment, Rosenthal holds this method to be the most energetic which we know of, against syphilis.

HOROVITZ.

## Selections.

### ON THE PRINCIPLES OF LOCAL TREATMENT IN ECZEMA.

DR. A. JARISCH says (in the *Centralblatt für Therapie*, January, 1888), that among the numerous remedies which come into use in the treatment of eczema, there is scarcely one which under certain conditions, and in particular stages of eczema, is not capable of causing injury. He who expects by good fortune to hit upon the right treatment will have more failures than successes in eczema.

Rational treatment of eczema leans more toward the negative than the positive side.

There is no specific local treatment for eczema; it is and must ever remain a symptomatic one.

Before we ask ourselves what treatment is appropriate to the symptoms present, we must consider the irritability of the whole skin. This irritability does not remain the same at all times, but changes according to the stage of the disease, the various local conditions, and the individual. It is most intensified in acute eczema, but is also found in the chronic form, especially at the time of exacerbations, as is shown by papular and vesicular forms of eczema.

It results, that the effects of any single remedy are not constant, that a preparation which in one case gives us the best results, in another makes the condition worse.

The greater the irritability present, the milder should be the remedy used.

All the remedies at our command in the treatment of eczema can be placed in one of three categories, according to their indications and effects:

1. Drying and protective.
2. Softening and macerating.
3. Hyperæmia lessening and cornification promoting remedies.

In the first category we have dusting powders, and especially Lassar's paste, with the formula:

R. Acid Salicylic.....	0,5 to 1,00 gram.
Pulv. Zinci oxidl.	
Pulv. Amyli pur. ā ā.....	5,00.
Vaselin, flavi puri.....	10,00.

This is to be applied over the diseased area in a thin layer by means of the finger, and then powder is to be thoroughly dusted on. It is applicable to all cases and locations in which excessive irritability is a contra indication to the use of the remedies of the other categories. Here, first of all, must be mentioned acute eczema, in which it is the rule, after the use of the paste and abundant powdering, to note the decrease in the subjective manifestations of tension, burning and itching. By its covering, drying and protective properties, the paste fills in the best way all the indications.

It is also valuable in chronic cases in those places where papular or vesicular eczema appears, not from any specific effect of the paste, but surely and solely by forming with the powder a drying and non-irritating covering.

All dusting powders are good which are fine enough and which do not contain injurious substances. Plain potato, corn or rice starch will do about the same service as those made more expensive by the addition of oxide of zinc, violet root, gypsum, etc.

In the second category of remedies whose office is to soften and macerate the parts, we find solutions, a numberless variety of salves, salve soaps, soaps, plasters and plaster mulls.

The indications for their use is found in the presence of heaped-up products of diseased processes of the skin and in excessively dry skins. The good effects are produced in the first place by removing the bad effects brought about by the shutting in and decomposition of the eczema secretions underneath the crusts, and partially by softening and rendering supple a skin inclined to fissure.

Beyond these indications for their employment we have no right to go with these remedies, for experience has taught that we only dare to cause maceration, without fear of injury, where there is something to macerate.

In case of papular and vesicular eczema, where there is nothing to soften, the remedies of the second category accomplish little or nothing, and often increase the disease.

The number of salves is legion, and if we ask ourselves, why in one case we employ diachylon salve, for example, and in another zinc or salicylic, we can only say, that it is not so important what composition the salve has, and, other things being equal, the salve of greater consistence is a much better macerating salve than a thin one made with vaseline, which readily melts at the temperature of the body.

Where fat is not well borne by the skin, the author recommends as an efficacious and not dear substitute, the five to ten per cent. salicylic soap plaster recommended by Pick. Some cases of eczema are made worse by it, although for the vast majority it is unirritating, and such cases would probably be made worse by any maceration. When several patches are separated by sound skin, they should never be covered with a single plaster, or they may run together, but each spot should be separately covered, and the whole powdered over or covered with Lassar's paste. Beside the office of softening diseased products and removing them, fatty substances prevent cracking of the dry epidermis and allay the itching. The choice of preparation will depend upon irritability of the skin, but under all circumstances lanolin will be found useful, either used alone or with the addition of ten per cent. of olive oil to make it more easily rubbed in, or in the form of a ten per cent. bor-lanoline, or a one or two per cent. salicyl-lanoline ointment.

The third category to which tarry preparations belong is indicated in scaly, hyperamic conditions of the skin. Even if we do not know in just what way tar works, we see its good effects in the decrease of hyperamia, and in the favorable influence on the process of cornification; but it is to be employed in the squamous stage, and as exceptionally it has an irritant effect, it should be used at first only upon a limited area.

Inasmuch as tar also exercises a drying effect, it is best used with an addition of a softening remedy and may be diluted from ten to fifty per cent. with olive oil, lanoline, etc.

To allay itching, may be employed an alcoholic wash containing from one to three grains of carbolic acid, and thirty grains of glycerine to three hundred of alcohol.

In cases of eczema where the excessive irritability of the skin has disappeared, a more irritating course of treatment can be carried out, such as the application of green soap, washes, rubbing with unguent contra scabiem, or a ten per cent. pyrogallol salve, and better results obtained than by the unirritating treatment.

### TREATMENT OF STRICTURE.

A COMPARISON of gradual dilatation, divulsion, internal and external urethrotomy, in the treatment of urethral stricture, was made in a recent paper by Dr. F. S. Watson (*Boston Med. and Surg. Journal*, December 29, 1887).

He assumes the acceptance of urethral measurements according to Otis's standard, and that strictures of the anterior urethra contract more readily after dilatation than deep ones.

While gradual dilatation is agreed to be the safest method, it cannot be advantageously applied to resilient strictures, to impermeable strictures and to such as are so dense that the force requisite converts the operation into one of divulsion.

Permanent cures by gradual dilatation are not to be expected. Out of one hundred cases treated by gradual dilatation the author has had but six cases in which a cure seemed to result, all being of recent formation and wide calibre. The chief reason for using gradual dilatation is that it allows the patient to go about his business, and in the deep urethra, except in cases where rigors, etc., follow its use, it is safer than divulsions or internal urethrotomy. The author has failed to find claims of permanent cure from divulsion, and has never seen a supposed cure in which relapses did not occur. The operation lacks scientific accuracy and lays the foundation for denser connective tissue than was originally there.

The mortality from internal urethrotomy is about the same as that from divulsion, *i. e.*, from one to five per cent.

The author has performed twenty-three internal urethrotomies without a death or any serious symptom. There is greater liability to hemorrhage from cutting in the deep urethra than from divulsion, and many of the most ardent advocates of internal urethrotomy do not cut beyond five inches. Internal urethrotomy the author regards as a safe procedure, and while he does not claim that it invariably leads to permanent cure, it gives a period of relief always measured by years, and often by a long term of years. The author quotes the opinions of many eminent men of this and other countries, in favor of internal urethrotomy over divulsion. Personally he has operated

upon twenty-two cases during the past six years, and has, for the most part, had them under observation since the operation. Thirteen are not obliged to use any sounds, have had no recontraction and no symptoms; four cases have been but recently operated upon, and four have been lost sight of. With an occasional exception, the operation has given entire immunity for periods varying from one to six years.

The mortality from external urethrotomy based on a calculation of more than a thousand cases taken from Gregory's tables and other sources—since the days of antiseptics—is, at the highest, eight per cent. His own external urethrotomies number eight, all of which were successful. Practically no mortality is attached to perineal section for purposes of exploration of the bladder, and the author believes that if external urethrotomy were performed earlier the mortality would compare favorably with that of divulsion or internal urethrotomy, and he suggests that the operation be not reserved until retention and extravasation are actual present dangers. The permanency of results, however, he considers not so good as those of internal urethrotomy.

His conclusions are :

1. All strictures anterior to five inches are best treated by internal urethrotomy. Dr. Otis's operation yields the most enduring results.
2. Divulsions should be rejected as an operation for stricture, unless it can be shown satisfactorily that where carried sufficiently far it yields as permanent results in as many cases as internal urethrotomy.
3. Dilatation, where practicable, should be employed in strictures deeper than five inches.
4. For stricture deeper than five inches not suitable for dilatation, external urethrotomy should be selected, and not reserved for an emergency operation only.

In the discussion which Dr. Watson's paper elicited, Dr. Greenough doubted very much whether internal urethrotomy or any other operation, can be considered in itself as an absolute cure for stricture. The fibrous tissue must be replaced by tissue of the same character. After-treatment is necessary.

DR. CABOT said strictures in the pendulous urethra almost always involve the mucous membrane to a certain degree, as well as the connective tissue between it and the corpus spongiosum; here the cutting operation is by far the best. That it is as curative as Dr. Otis believes, he thinks almost no one would claim. For many strictures of the deep urethra external urethrotomy seems an absurdly grave operation. Where the stricture consists in a little fibrous cord surrounding the urethra, it may be broken by divulsion and done away with, and in such cases divulsion is the best operation. By subsequently passing large sounds, the hope of a permanent result is very good. In deep strictures in the softer parts, he does not think the teasing from divulsion is so severe as has been represented.

### HYDATID URTICARIA.

DR. DEBOVE has studied the pathology of Hydatid Urticaria (*Le Progres Medical*, December 31, 1887). In patients with hydatid cysts an urticarial eruption often occurs, either following a puncture or spontaneous opening of the cyst into the peritoneal cavity. The author has been enabled to demon-

strate that the urticaria is the result of an auto-intoxication, and that different patients are unequally predisposed. In fact, after having filtered the transparent liquid drawn off by puncture of a hydated cyst, he had injected a Pravaz syringe full of it at three different points beneath the skin of the abdomen, in three subjects who had never had any urticarial eruption. The first subject gave a negative result. The second had a urticarial eruption localized at the three points inoculated; this eruption appeared as papules at the end of ten minutes. The third subject had at the outset a localized eruption as in number two, but twenty minutes later there appeared four large plaques of papular urticaria upon the back, and six hours later other plaques became confluent upon the fronts of the arms and fore-arms.

### PREPUTIAL DILATATION IN PHIMOSIS.

Dilatation of the prepuce is an operative procedure which has had a certain seduction for some surgeons in the treatment of phimosis because of its simplicity, rapidity of execution and the slight amount of pain occasioned by it. Long ago proposed by Nélaton, it has of late years been brought forward by Verneuil and Saint Germain. Although sufficient for some cases, in others it does not completely meet the indications, and in some it may become the source of complications.

In young children dilatation is practiced in the following manner: local anæsthesia is secured by ice, ether spray, or by cocaine. In very young children this is not necessary. The region is then explored with a blunt pointed probe, to see if adhesions or calculus are to be found. Slight adhesions can be broken down with the probe, or possibly more firm ones may be cut by introducing a small pair of scissors. If the adhesions are very firm, dilatation is contra indicated. The penis is then carefully washed with a non-irritating antiseptic solution. A straight bladed dressing forceps or three bladed dilator is then introduced carefully to the bottom of the balano-preputial fold. The blades are then slowly separated until the prepuce is double the size necessary to allow the glans to pass. The prepuce is then retracted, to see if it moves freely in both directions. Each day during the next eight or ten days this manœuvre should be repeated.

There is but slight swelling after the dilatation, and it may be treated with compresses wet in a four per cent. boric acid solution. Cure is complete in six or eight days.

Where the orifice will not admit a dilating instrument, of course this cannot be done, and it is contra indicated in simple atrophic phimosis.

In the adult the operation presents more inconveniences than advantages. Still some have employed it with success. Ordinarily beyond the age of fifteen the prepuce becomes indurated to such an extent that a large tear is likely to occur. In phimosis consecutive to a balano-posthitis, and in cases of hypertrophic lengthening of the prepuce, circumcision is better. (Dr. Barette, in *Le Concours Medical*, December 3, 1887.)

### ERYTHEMA PAPULATUM OF THE BUTTOCKS IN INFANTS.

Dr. Sevestre (*Le Concours Medical*, December 17, 1887) claims that it is at times quite difficult to distinguish between papula erythema of the buttocks in infancy and a papulo-erosive syphilide, if one has not observed the eruption from its onset. They are dark red in color, or sometimes shading

into brown or violet, are flat and firm with shining epidermis in the centre. Erosions having the same form are found alongside the papules. The prominent parts of the buttocks are those occupied by the eruption which does not involve the natural folds of the skin.

The lesion begins as a vesicle followed by an erosion, and the papule after lasting a few days disappears, leaving a brownish macule which persists for some time. The contact of urine and feces of diarrhoea is the exciting cause. It is observed about the fifth or sixth month. The appearance of the papule in full development is the same as that of syphilis. To make the diagnosis we must take into account the absence of other symptoms, the localization of the eruption, the coexistence of vesicles and erosions, and the rapid cure on removing the causes of irritation.

### RESORCIN IN GENITO-URNIARY DISEASES.

DR. ANDEER (*União Medica*, Oct., 1887) is convinced that resorcin is a remedy uniquely antiseptic in a great variety of affections, in which, from the beginning of the disinfection, the concomitant fever is seen to disappear entirely. In truth, it does not cut short the fever at once at the beginning of the aseptic action in the same way that quinine, antipyrin and kairin do, but accomplishes it by, first of all, suppressing the infectious matter.

It is an excellent disinfectant in adenoid tuberculosis and carcinomatous degeneration, and is not less efficacious in all hyperplasias, desquamations, rhagades, fissures, cicatrices, erysipelas, eczemas, and in all the exanthemata of the genital organs as well as of other parts of the body. It is not injurious to instruments. Resorcin is easily applied, especially in gynecological practice, and is without any danger. The author cites five cases in which the interior of the uterus was cauterized with resorcin, for a variety of morbid conditions, with marked success.

The resorcin must be chemically pure, and when so the author has found it of constant benefit in gonorrhoea, and not irritating, as is the impure article.

In gonorrhoeal cystitis, where the urine is either neutral or alkaline, from one to three injections are sufficient to cure acute cases, and, where chronic, about half a dozen are needed at intervals of two or three days. In syphilitic, tuberculous and cancerous degeneration of the bladder, resorcin can have no specific claims made for it, but it can fill the rôle of a very active and perfectly inoffensive disinfectant, producing comfort which of itself is most valuable.

Solutions varying from two to fifteen per cent. are employed.

### ARE THE TERTIARY PRODUCTS OF SYPHILIS INFECTIOUS OR NOT?

According to Zeissl (*Deutsche Med. Zeit.* December 15, 1887), the question of the infectiousness and transmissibility of the products of tertiary syphilis can be summed up in the following conclusions:

1. The offspring of those having tertiary syphilis are, as a rule, healthy.
2. The secretion from broken down primary sores and the products of

the papular stage of syphilis brings forth a syphilitic reinfection in those affected with gummy nodes :

3. Inoculations with the secretion of gummy nodes have never succeeded.

In opposition to these three arguments of those who do not believe in the infectiousness of tertiary syphilis, the following points can be raised :

1. By many authors it has been shown that tertiary syphilis is transmissible, even if in extremely rare cases. This probably depends upon the length of time since the existence of the primary lesion of the parent. On the other hand, it is not imperative that syphilitic parents should beget syphilitic children, as it is well known that even parents in the secondary stage have had healthy children.

2. Up to the present time there are but few cases of syphilitic reinfection in those with tertiary syphilis, and even these few are doubtful, since, in these cases, the course of the second infection was quite unusual.

3. Inoculation with the secretion of the products of tertiary syphilis are as yet only few in number, and negative results are never convincing.

It is often seen that inoculation with the secretions of the primary and secondary lesions frequently fail.

Beside the above, the following points favor the infectious nature of tertiary manifestations.

Gummy nodes have a similar histological structure to that of the papule and primary lesion. In the same class of tumors belong, according to their microscopical appearance, the products of tuberculosis, lupus, lepra and glanders. These are all granulomata, and the diseases are, as a whole, infectious, as is also shown by the demonstration of specific micro-organisms in them.

The sure proof of the syphilis bacillus, would here add much light to the subject.

From the above it is clear, that, in the present state of our knowledge, the question cannot yet be settled.

### INTERNAL TREATMENT OF LICHEN.

VIDAL recommends frequent purges in the treatment of lichen, and for the purpose we may employ senna, natural mineral waters, bitter drinks, such as are made with hops, gentian, etc. If the patient be gouty, alkalies are to be prescribed. If the eruption be dry, and if thickening and roughness of the skin persist, it is well to combine with the bitters the phosphate of lime and cod-liver oil.

In case of intense pruritus and insomnia, opium by the mouth and morphine by subcutaneous injection. Bromide of potassium and chloral also give good results, but they also at times cause eruptions. When pruritus is intense, we may resort to a potion containing four grains of tincture of musk.

In chronic and rebellious forms we may try the following solution: Arseniate of soda ten centigrams, distilled water 100 grams, of which a teaspoonful may be taken each morning just before eating. At the end of seven or eight days the dose may be doubled.

Coffee, tea, strong wine, liquors, salty meats, pork, game, cheese, shell fish and salt-water fish generally, must be excluded from the dietary. So, also, must late hours, muscular fatigues and violent emotions be avoided. (*Gaz. Méd. de Nantes*, Dec. 9, 1887.)



## Items.

**THERAPY OF ECZEMA.**—Letzel recommends (*Deutsche Med. Zeit.* 100, 1887) the following lotion :

R. Olei Papaveris.....	99,0
Coque c.	
Acidi Salicyl. lævig.....	1,0
in balneo usque ad perf. solut., refrigerat adde,	
Aquæ Calcis.....	100,0
Zinci oxid. subtiliss.....	15,0
Sensim toreando.	

Sig.—Shake before using.

On account of its cheapness it can be used in dispensary practice, and if desired, other drugs may be substituted for the salicylic acid.

### MANIFESTATIONS OF GOUT UPON THE GENITAL ORGANS.

—According to a recent thesis of Dr. Legalcher, gout may show itself in man by a subacute urethritis, by dermatoses of the glans, prepuce and preputial fold, by a special form of orchitis, and by a prostatitis.

In women, we observe a metritis, a vaginitis, and a vulvitis of gouty nature, alternating with other manifestations of the diathesis. They resist all treatment not directed against this diathesis. Such are the characteristic signs, which, however, are far from being always definite. (*Gazette Méd. de Nantes*, Dec. 9, 1887.)

**TREATMENT OF PANARIS.**—At the outset of inflammation, Polaillon says (*Gaz. Méd. de Nantes*, Dec. 9, 1887), apply carbolized oil or tincture of iodine, followed by emollient and narcotic applications with the hand in an elevated position. If the inflammatory condition increase, an incision to the bone is to be made in the median line, if the last phalanx is the one involved, but not including the sheaths if the first or second phalanx is the one affected. Immediately after the incision the finger must be placed in an antiseptic bath and then dressed antiseptically. In subcutaneous panaris an incision should be made just as soon as suppuration is suspected, care being taken not to cut the lateral surfaces of the finger.

**CORRECTION.**—In Dr. Piffard's paper, p. 42, sixth line from bottom, read chlorate for chloride of potassium.

## Books and Journals Received.

A PRACTICAL Treatise on Diseases of the Skin, by John Shoemaker, A. M., M. D., with Colored Plates and other illustrations. New York : D. Appleton & Co., 1888.

The New York Medical Journal Visiting List and Complete Pocket Account Book. New York : D. Appleton & Co., 1888. This Visiting List, by Dr. Charles H. Shears, is prepared in a new system of arrangement, and possesses certain peculiar advantages which will no doubt commend it to the favor of the profession.

TRANSACTIONS OF THE AMERICAN DERMATOLOGICAL ASSOCIATION AT THE ELEVENTH ANNUAL MEETING IN BALTIMORE, 1887. *Official Report of*

*the Proceedings by the Secretary* contains an abstract of the papers presented, with full reports of the discussions. Report of the Committee on Statistics, with a list of the contributions to Dermatology published by the members during the year ending July 1, 1887. We observe that there is no mention made of the names of the presiding society officers of the society for the year just closed, an omission no doubt inadvertent, on the part of the Secretary.

Tubercle of the Testis, by R. W. Taylor, M.D. (Reprint.)

Foot and Mouth Disease as it affects Man and Animals and its Relation to Human Scarlatina as a Prophylactic, etc., by J. W. Stickler. (Reprint.)

Observations on Three Cases of Symmetrical Hand and Foot Disease, by J. Nevins Hyde, M.D. (Reprint.)

On the Occurrence of Small-Pox Lesion in the Internal Organs, with some Studies of the Skin Eruption, by John T. Bowen, M.D. (Reprint.)

Wounds. Their Septic and Antiseptic Management, by Dr. David Prince, M.D. (Reprint.)

Report on Progress in Medicine, by J. B. Marvin, M.D. (Reprint.)

The following reprints from Dr. P. G. Unna, of Hamburg:

Die Salbe sonde bei Behandlung der chronischen Gonorrhoe.

Ueber die neueren Fortschritte in der Behandlung der Hautkrankheiten.

Ueber weiten Versuche. Farben auf dem Gewebe zu erzeugen und die chemische Theorie der Färbung.

Ueber Hautklemmen.

Ueber Seifengeist.

Gläserne endoskope.

Die Neuester Form meines Suspensoriums.

Die feinere struktur des Leprabacillus.

Was wissen wir von der Seborrhoe?

Ein neue Darstellung's Methode des Elastischen Gewebes der Haut.

Das Seborrhoische Ekzem.

Die medicamentösen Leime.

Ueber Stabiles Oedem, von Dr. Oscar Lassar. (Reprint.)

Klinische Beiträge Zur narben verbesserung, von Dr. Oscar Lassar. (Reprint.)

Ueber das Soziodol, von Dr. Oscar Lassar. (Reprint.)

Beitrag zur Lehre von Fibroma Molluscum, von Dr. A. Philippon. (Reprint.)

Die Béniqué Sonde, von Dr. Feibes. (Reprint.)

Ueber Pediculosis, von Dr. H. Goldenberg. (Reprint.)

Zur Auflösung harnsaurer Concretionen, von Dr. C. Posner und Dr. H. Goldenberg. (Reprint.)

La Calochelleite dei Mietetitorin, Cunideraziozi sopra un affezione speciale del labbro inferiore, Dr. P. Tommasoli. (Reprint.)

Contributo allo Studio del Milza in rapporta calla Sifilide, Dr. P. Tommasoli. (Reprint.)

Sulla Transmissibilita del Psoriasi nel coniglio, par Dr. P. Tommasoli. (Reprint.)

L'iniettore uretrale d'unguenti, Dr. P. Tommasoli. (Reprint.)

Considerazioni sulla natura del Ittiosi, Dr. P. Tommasoli. (Reprint.)

Ueber den Inneren Gebrauch des Ichthyola, von Dr. Von Nussbaum. (Reprint.)

JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

APRIL, 1888.

No. 4.

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**Original Communications.**

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PEMPHIGUS ACUTUS SEU FEBRILIS—CASE.

BY

CHARLES W. ALLEN, M.D.,

Surgeon to Charity Hospital, Attending Physician, for Skin Diseases North Western  
Dispensary and for Genito-Urinary Diseases at the out-door  
Department of Bellevue Hospital.

**P**EMPHIGUS of any variety is a rare disease and the existence of an acute form has been questioned by many dermatologists. Hebra said "Doubts may be fairly entertained as to the existence of a Pemphigus Acutus." Willan and Bateman, according to Cazenave also denied the existence of an acute pemphigus. McCall Anderson in his recent work says he has not met with so called febris bullosa, or acute pemphigus, and out of 24,891 consecutive cases of skin disease there were only fifty-three of pemphigus, of all varieties. A similar proportion holds good for this country, Bulkley reporting seventeen instances in 8000 cases. Duhring recognizes an acute form but says it is exceedingly rare except in children, Pemphigus in the adult having an essentially chronic course.

Cazenave gives an excellent description of the acute disease.

Tilbury Fox says there is an acute form of pemphigus but that it is seen in children and is synonymous with pemphigus

neonatorum and that there is a non-syphilitic and a syphilitic form.

Indeed most cases of acute pemphigus which have been reported have occurred in children.

Authors say that the eruption appears usually upon the hands and feet. There is this peculiarity about pemphigus that no two cases are just alike and there is no such thing as a perfectly typical form of eruption. Notwithstanding the various appearances presented by bullous eruptions and by pemphigus in the two forms described by almost all authors as pemphigus vulgaris and pemphigus foliaceus, Hebra thought that those bullous eruptions should not be named pemphigus which did not conform to the type described by authors. In acute pemphigus, however, we have a disease which this great author had never seen, and hence could not describe to guide us. In his vast experience covering 80,000 cases it had not occurred, nor had his colleagues in Vienna met with a pemphigus running its course after the manner of the exanthemata. He admitted that one or two bullæ might come and disappear, especially in patients with blood poisoning or as the result of metastasis. He says "No one would think of saying that variola was present because there were two pustules on some part of the surface." However, at the present day I think this view will not be accepted, and that two typical variola pustules in a subject presenting all the other signs of the disease would be regarded as sufficient for a diagnosis. I have surely seen cases of small pox in which the number of pustules was extremely limited. Before we can regard a bullous eruption as surely one of pemphigus, we must exclude all the bullous forms of drug eruption which have been so much discussed of late, and which Morrow has so well described in his recent work. I have seen a number of cases of bullous eruption from iodide of potassium and some from the use of drugs externally. Hardy has reported a case of "acute pemphigus" from the internal use of copaiba.

Furthermore, we must exclude or not confound with pemphigus the other diseases in which bullæ form, such as herpes, especially herpes iris, urticaria bullosa, erysipelas, eczema, impetigo, scabies, pomphylx, erythema bullosum, hydroa, the specific diseases, syphilis and lepra, blood poisoning, artificially produced and feigned eruptions, and the ephemeral solitary bullæ, due to pressure, cold, heat, etc., or in other words common blisters, and occasionally bullous lesions of variola, varicella and vaccinia. Acute pemphigus appears to

have been described as early as 1618 by Lepois, and Willan collected cases and gave an excellent description of it just eighty years ago.

Dr. Damon, in an excellent article on the subject, which appeared in the *Archives of Dermatology*, July, 1881, divided Willan's description of a typical case into *stadium prodromorum*, *eruptionis*, *floritionis* and *decrustationis*, and it is found to conform very well to the successive stage of the exanthemata.

Rayer (*Maladies de la peau*, 1835), says acute pemphigus occupies the lower extremities most frequently. The arm, trunk and face next, and in rare instances, the soles, scalp and genitals.

Various authors have in recent years reported cases of acute pemphigus in adults. Still the total number from all sources is limited. Dr. Levisseur, now of this city, reported a case in his inaugural dissertation on pemphigus, at Göttingen, in 1884, and refers to Köbner's case in an adult,<sup>1</sup> also mentioned by Kaposi, who says he has never met with the disease.

The following is the history of a patient who has recently been under my care and whose eruption is well shown in the accompanying colored picture :

James M—, æt. 33. Native of the United States, blacksmith by occupation, was admitted to Charity Hospital, January 16, 1888. Father killed in war and mother died of cholera. Patient had yellow fever in 1878, and has since then had chills and fever, pneumonia, and rheumatism, but never any previous eruption. There is no history of syphilis, but patient says he had a bubo and soft chancre ten years ago. Patient has recently been in good health until January 10th, six days before admission, when he first noticed an intense itching in the axillæ, over the chest, abdomen and inner sides of arms, in fact, in the regions upon which the eruption subsequently appeared. Two days after the itching began, he had a severe chill and felt sick, was nauseated and felt "sore and uneasy inside." This same night he noticed that the itching had stopped ; he was restless and unable to sleep, and during the night discovered small blisters upon the chest, inner sides of arms and scalp, which were about the size of coffee grains. The next day more blebs appeared, and some of the first crop increased in size. On the 14th, patient said he felt chilly, his skin was hot and he was thirsty, but afraid to drink anything excepting hot drinks. Does not think he slept on the nights of January 14th and 15th, as he was

<sup>1</sup> Archiv für Dermatologie, 1869.

very restless. Upon admission to Charity Hospital on the 16th, patient was so weak that he could scarcely stand. Felt feverish, had bad taste in the mouth, tongue was dry, rough and thickly coated, and he was constipated. Pulse 96 and weak. At this time there were about a dozen bullæ scattered over the chest, abdomen and back, from the size of a twenty-five to a fifty cent silver piece, and smaller ones upon the scalp and arms. Some were tensely distended with purulent fluid, and in some the walls had collapsed. Some contained a yellow and some a pearl colored fluid. No preceding erythematous spot was noted, but surrounding the bullæ was a pink areola, not over an eighth of an inch in width in most cases. The intervening skin between the lesions was perfectly normal.

Bullæ varying in size from a pea to a hen's egg and even larger, continued to appear almost daily until January 24th, when some of the largest ones appeared upon the abdomen, and small ones in groups upon the right shoulder, and upper portion of the chest. At this time bullæ in all stages were present, and the bright red circular excoriated surfaces left by the earlier bullæ, which had lost their covering presented a remarkable picture, as will be seen by the frontispiece plate. Many of the bullæ upon the back became confluent, and being early ruptured by the decubitus left large excoriated surfaces. With the exception of a single lesion just above the right ankle the bullæ did not extend upon the extremities beyond the elbows and the knees. The skin upon the forehead became erythematous about the 18th—and two days later the epidermis was raised by fluid and soon became detached, leaving a condition similar to that produced by a blister. Crusts, at first yellow, which later on became brownish and crumbly, formed upon the scalp and neck, and the fluid which escaped from many of the bullæ was extremely offensive. In the larger bullæ the fluid soon became turbid, containing floculi like the curd of milk and in those the size of a goose egg became greenish. A few became hemorrhagic. The reaction of the fluid in the recent lesions was alkaline and in the older ones acid. The bullæ were for the most part quite circular, but some were oval, quite tense, and markedly raised above the surface, some being fully an inch in height. After rupturing or being opened in spite of careful dressing the walls were soon detached, leaving a bright red, moist or glazed surface. None of the lesions went on to ulceration but healed rapidly, and no scars were produced, but redish, bluish or pigmented spots have since

persisted. The temperature for the first week after admission was not accurately accorded but was elevated despite the constant administration of quinine. The temperature for the next three weeks showed the following variations :

Jan. 23, a. m.,	100.6	p. m.	100.0	Feb. 3, a. m.,	98.8	p. m.,	104.4
" 24, "	100.4	"	100.8	" 4, "	98.5	"	99.6
" 25, "	98.3	"	100.6	" 5, "	99.2	"	100.4
" 26, "	....	"	103.4	" 6, "	98.6	"	99.0
" 27, "	98.3	"	101.4	" 7, "	....	noon,	100.4
" 28, "	101.4	"	104.6	" 8, "	98.5	p. m.,	99.0
" 29, "	98.5	"	101.0	" 9, "	99.0		
" 30, "	97.8	"	99.8	" 10, "	....	noon,	98.5
" 31, "	99.0	"	99.8	" 11, "	98.5	p. m.,	99.0
Feb. 1, "	100.4	noon,	97.2	" 12, "	98.5	"	99.0
" 2, "	....	"	104.4				

Whenever the thermometer showed an elevation of 103° or more, antipyrin was usually given, but from January 29th to February 2d, quinine was used.

*Treatment* consisted, at first, in the administration of quinine and tonics containing bark and strychnine. Antipyrin was given when the temperature became high. Fowler's solution was begun after 4 or 5 days, and increased gradually from 5 to 15 drop doses thrice daily. Arsenic was taken until February 1st. On the morning of January 30th, 25 grains of quinine were given on account of chill. The temperature became subnormal, and only went up to 99.7 in the afternoon. On February 1st, there was a slight chill, and ten grains of quinine reduced the temperature to 97.4; but the next day it went up to 104.2. Local treatment consisted in careful pricking and evacuation of contents of the larger bullæ, and the application of a protective paste made with starch and bismuth spread upon sheet lint and retained with gauze bandages. Antiseptic washes, naphthol oil to the scalp, etc. In this case then, there was a clear history from the patient, of a prodromal stage lasting from 2 to 3 days; so far as the patient noted his symptoms, in which itching, heat of skin, chill, and malaise were the chief symptoms. This was followed by a stage of eruption in which some symptoms, especially the itching, disappeared; then followed a stage of efflorescence lasting 9 or 10 days, the bullæ appearing in crops about every second day, springing from apparently sound skin, and not preceded by an erythema, excepting in the lesion upon the forehead, some lesions being practically well before the last crop appeared.

The fourth and last stage, or that of decrustation, may be said to have extended from January 24th, when the last crop of bullæ was noted to complete recovery, about February 8th; the whole course of the disease occupying about a month.

The temperature in acute febrile pemphigus appears to vary quite as much as does the distribution of the bullæ in different cases. In Dr. Levisseur's case either the temperature was low the first week or was not recorded, for his fever tracing begins a week after the first eruption. For about 5 days the temperature ranged from 103 to 104.5, then for five more at about 101-102, finally reaching the normal in the third week.

The diagnosis of acute pemphigus was made early in the disease, in the case I have described, because of its onset in a healthy man without previous skin lesions or erythema preceding the bullæ, the prodromal symptoms and fever, and the severity of the affection. As the disease progressed I saw no reason for changing my mind in regard to it. The patient though practically well since about February 8th has been kept under observation and no signs of a new eruption have appeared. The urine has contained no albumen.

In chronic pemphigus there is little or no fever, and the general health often appears good. The following case was in Charity Hospital about four years ago.

PEMPHIGUS CHRONICUS.

Wilhelmina D—, æt. 56, was admitted October 1, 1884. Four weeks before admission patient noticed an eruption of blisters upon the chest, which, in two days, covered the whole body. Before the blebs broke, they itched and burned and new crops continued to appear every day.

On October 8th—a week after admission—a new crop of small vesicles and bullæ appeared upon the left arm. These increased in size and new crops appeared, varying from the size of a pin's head to a pigeon's egg. These continued to appear until the 18th, on the fingers, hands and feet, as well as other parts of the body.

On October 21st, vesicles reappeared.

On October 31st, vesicles reappeared.

On November 2d, vesicles on back of neck.

On November 3d, bullæ, size of pigeon's egg, were noted, and during the whole month of November, bullæ continued to appear.

December 2d, arms completely covered with small vesicles, close together, and there were large blebs upon the feet.



11th. Completely covered from head to feet.

14th. Vesicles in ears, in mouth and at edge of eyelids.

Free from 18th to January 4th, when new crop appeared, and during the next seven months occasional eruptions were observed. Patient was discharged August 28, 1885, recorded as "improved."

As to the nature of acute pemphigus in the adult I think we must regard it as an eruptive fever or bullous exanthema, closely allied or identical with the acute pemphigus of infancy, although there appears to be a form of the latter which is contagious and has been observed as an epidermic affection. In 1884 Colrat<sup>1</sup> found a micrococcus in the bullæ of acute pemphigus which existed in epidermic form among infants. This micro-organism was cultivated, inoculated upon one of the children and a bullæ produced at the point inoculated.

In 1880 Spillman found short rods in the fluid of bullæ of acute pemphigus which were similar to those found in puerperal fever, and in 1885 he discovered in the blood, the urine and the contents of the bullæ in a case of acute pemphigus in the adult rounded spores, which he described at the Congress of Grenoble.

Gibier<sup>2</sup> thought he had found the infectious agent of acute pemphigus in a bacterium which he discovered in the bullæ, and in the urine and was able to cultivate. Haushalter who quotes these observers in an article on polymorphous erythema<sup>3</sup> has himself found in a bullous eruption in a young man, micro-organisms which he cultivated and was inclined to believe were other than ordinary microbes of suppuration.

This author thinks that cutaneous eruptions in variola scarlatina, syphilis and the like, is due rather to direct action of the virulent agent in the skin than to its effect upon the vaso-motor centres as Lewin believed.<sup>4</sup> He quotes Neuhaus,<sup>5</sup> who found the bacilli of typhoid fever in the rose colored spots upon the skin in nine cases out of fifteen, and cultivated them.

In conclusion my case was surely not one of erythema multiforme, which in its bullous form, Fox<sup>6</sup> says, is usually the disease called acute pemphigus. That it might be the beginning of the chronic form I admit, though the symptoms and

<sup>1</sup> Revue de Méd.

<sup>2</sup> Annal de Derm. et de Syph. Nov. 1882.

<sup>3</sup> Annal de Derm. et de Syph. Nov. 1887.

<sup>4</sup> Berlin Klinn Wochenschr, Nov. 23, 1876.

<sup>5</sup> Berlin Klinn Wochenschr, Nov. 6 and 24, 1886.

<sup>6</sup> Photographic Illustrations of Skin Diseases.

course answer to those carefully observed and described acute cases found in literature. Should, however, no new eruption appear until, for instance, the same time next year, as is seen in some cases of pemphigus, I would regard it rather as an acute disease with tendency to recur rather than as a chronic affection.

No. 102 EAST 57TH STREET, NEW YORK.

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KERATOSIS FOLLICULARIS, ASSOCIATED WITH AN EXAGGERATED TYLOSIS OF SOLES AND PALMS.

BY

E. A. NEELY, M.D.

THE case I here describe came under my observation during the past summer, and from its peculiar development and rare clinical characteristics, is one deserving a more permanent record than is afforded by my note book.

The patient was a negro boy sixteen years of age, brought here from Mississippi to Dr. T. J. Crofford, and referred by him to me. The boy was semi-idiotic, consequently only that part of his history known to Mr. B——, the gentleman who brought him here, and in whose possession or care he has been for the past thirteen years, could be obtained. At that time, when he first came into the possession of Mr. B——, and when he was only three years old, the disease existed as a tylosis, general in character, covering the entire surface of the soles of both feet. This condition has slowly but constantly increased, and exists now in a very remarkable and exaggerated degree, being greatest at the edges where least subject to pressure. I approximated the thickness of this cornification at its thinnest part—the middle of the sole—at half an inch. At the edges, of course, it was much greater. Deep fissures channeled it in every direction, and it could be cut, pulled upon or struck without the exhibition of any consciousness of the act upon the part of the patient unless his attention was directed to it. Its presence produced no inconvenience other than by acting as an impediment to locomotion.

Soon after coming into Mr. B——'s household the disease began to "spread" up over dorsum of both feet. Progressing steadily year after year, it now covers the feet and both legs anteriorly, to a point immediately above the knees; posteriorly, something above a point midway between heel and popliteal

space. Its extent may be seen by reference to the accompanying cut. The pathological condition, here, however, is a quite different one from that which I have described as existing on the soles of the feet. The leg looked as if covered by a mould coarsely granular in appearance, raised from one quarter to one third of an inch above the general surface of the skin, presenting here and there nodular elevations. To touch this substance gave a harsh, coarse, graty sensation which might be likened to that produced by rubbing the hand along the surface of an un-

dressed board. An attempt to scrape away this substance, that I might examine it more critically, proved rather difficult, as it seemed in some way to be attached to the skin beneath. This accomplished with a little persevering diligence, the skin was seen void of cuticle, which lacked the physiological conditions for formation, and studded with the patulous orifices of sebaceous follicles, dilated and projecting considerably beyond the general surface. From each gaping mouth hung a shred of mucoid-looking material, which seemed to have been forcibly

sundered during the process of removing the hard covering substance. This, I now came to the conclusion, was nothing more than accumulated and dessicated or cornified sebaceous secretion. Continuing my examination, I found that these shreds had their counterpart in the cone-shaped ends of the plugs I had removed by scraping. The appearance of the patch from which I removed this accumulated and dessicated sebaceous matter, with its conical plugs, was that which has been described as suggestive of the punched out holes of a nutmeg grater.

Within a zone of about three inches, surrounding the margins of the affection, were numerous groups of follicles which had taken on the diseased action. It was in this manner—the implication of groups and their ultimate confluence—that the disease had evidently spread. Scattered among these, and within an outer zone of much greater extent, were individual lesions in great profusion, each presenting the same characteristics described above, *i. e.*, the orifices of the sebaceous follicles projected above the normal skin, and were occupied by comedo-like plugs, the ends of which protruded more or less prominently.

About three years ago the same condition of tylosis which exists on the soles of his feet began to develop in the palms of hands, both simultaneously, and, as is shown in the cut, has steadily increased, but of course does not exist to so exaggerated a degree as on the soles. It was noticed, too, that the sebaceous glands on dorsum of hands and those near palm on flexor surface of forearm, were becoming involved, particularly those near the margins of palm.

The skin over the entire surface of the body was dry, rough and harsh, presenting that appearance denominated *cutis anserinus*. More correctly speaking, however, it was a keratosis pilaris of a mild degree, greatest near the disease, but slightly developed at remoter points.

Subjective symptoms, because of the boy's mental condition, were almost entirely absent. Mr. B—stated that he had occasionally observed him scratching or rubbing his legs with a board. Itching, however, could not have been very annoying or distressing to him, for neither the skin of the affected localities nor elsewhere presented evidences of very energetic scratching. The tendon reflexes were normal, and he could stand or move about with his eyes closed. He was moderately well developed for his age. His appetite and digestion were good and he slept

soundly—indeed, his general health was apparently excellent.

I put him on an iron, strychnine and arsenic pill twice daily, and began to act upon the tylosis of soles and palms and the dessicated sebaceous substance with *sapo viridis*, applied liberally. Under its influence after six or eight days' use, it had softened very preceptibly, and I had begun to entertain great hopes of its complete removal, but at this juncture the boy wandered off from the home of the negro family with whom I boarded him, and could not be found by the police, who had several times returned him to me. Quite a while after I learned that he had made his way, imbecile as he was, to his former home in Mississippi. The result of treatment, therefore, cannot be given, and I regret it very much, but still hope to be able to do so at some future time.

The treatment and its results, to my mind, constitutes one of the least interesting features of the case. Of far more interest and practical value is the consideration of the relationship between the tylosis of soles and palms and the sebaceous trouble, and further, of the relationship, if any, existing between these two and the patient's mental condition. Of far more interest also is the selection of the class to which we will assign it, and the name by which we will call it.

The nearest approach to a similar case to be found in the dermatological literature at my command is one which came under the observation of Dr. P. A. Morrow, of New York, and reported by him to the American Dermatological Association during the past year, in a paper entitled *Keratosis Follicularis, associated with fissuring of the Tongue and Leukoplakia Buccalis*. The interesting clinical feature of this case was "the implication of almost the entire follicular apparatus of the skin in a morbid process which had resulted in a dilatation and projection of the excretory ducts, and the presence of comedo-like plugs, which were altered in character and exaggerated in development." The case presented a specific history, dating, however, from a later date than the development of the keratosis or the leukoplakia and fissuring, thus excluding the idea of a cause and effect relationship between them. The only similarity between Dr. Morrow's case and the one I report, is in the morbid anatomy of the cutaneous follicles. His patient was a man of ordinary intelligence, the lesions were discrete and individualized but general, their appearance was simultaneous all over the body and were associated with fissuring of the

tongue and leukoplakia buccalis. My patient was a boy, semi-idiotic; exaggerated tylosis or keratoma has existed from almost infancy on the soles, developing later on the palms and from the margins of this the keratosis seemingly began, traveling in an opposite direction, involving all of the glandular structures in its progress.

I do not think there can be any doubt but that the morbid anatomy of the glands in both cases are identical. Therefore, I have no hesitancy in accepting the name, *keratosis follicularis* as the anatomically correct one for my case, recognizing the cogency of Dr. Morrow's reasons for its applicability. It is one, too, which Dr. Bronson has given to a species of keratosis in his clever classification of skin diseases presented to the last meeting of the American Dermatological Association.

When we come to consider the relationship, if there be one, between this boy's intellect and his local afflictions, we are necessarily plunged into the realm of speculation. But when we remember that the tylosis appeared simultaneously on the soles of both feet, or rather existed there with the beginning of his history at the age of three years; that the keratosis began at the margins of this, contemporaneously on both feet, progressing up both legs with equal stride, and that about six years later a tylosis developed at the same time in the palms of both hands, followed by the same phenomena as on the feet, with the same regularity and precision, we are forced to the contemplation of its origin in the central nervous system.

NO. 125 HERNANDO ST., MEMPHIS, TENN.

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#### THE MECHANICO-SURGICAL TREATMENT OF SKIN DISEASES.<sup>1</sup>

BY

P. A. MORROW, M.D.

**I**N the ordinary conception of the resources of cutaneous therapeutics, surgical treatment occupies quite a subordinate position. The armamentarium of the dermatologist is supposed to consist of drugs, rather than to bristle with surgical appliances.

A belief in the constitutional origin and nature of diseases of the skin has led to the general conviction, that the true principles of rational and successful treatment are based upon

<sup>1</sup> Abstract of a paper presented at the Annual Meeting of the New York State Medical Society, February 7, 1898.

the correction of the constitutional disorder, of which the cutaneous affection, it is assumed, is merely the local expression.

While certain skin diseases are purely idiopathic in their nature, depending upon functional or structural peculiarities of the individual skin, and which are neither the consequence nor the cause of general ill-health, yet it is undoubtedly true that a large proportion of the ordinary dermatoses have the closest and most intimate relations with derangements of the internal organs. Experience proves, however, that many symptomatic cutaneous disorders which are entirely refractory to the curative influence of any internal medication thus far discovered, are often readily amenable to local treatment.

The Hebraic, or Vienna School of dermatology owes its remarkable prestige and influence, not so much to the rejection of the diathetic doctrines of the old school and the substitution of a new etiological conception of cutaneous diseases, but rather to the clinical demonstration of the fact that in a large proportion of these diseases much more brilliant curative results may be accomplished by local than by general treatment.

Within the last few years cutaneous therapeutics has been almost entirely revolutionized by the introduction of fixed adhesive applications, the object of which is to confine the application of medicinal substances directly to the diseased surface, and to secure a continuous curative influence by maintaining the active agent in prolonged contact with the affected tissues by means of a practically immovable dressing.

While all such local measures may be properly included under mechanical methods, it is not my purpose in this paper to consider the value or the range of application of the various collodion, traumaticine and gelatine combinations, salve and plaster, muslins, etc., except as adjuncts to mechanico-surgical treatment by means of potential caustics, the Paquelin or galvano cautery, cutting, puncturing or scarifying instruments, electrolysis, etc.

The cutaneous diseases in which mechanico-surgical treatment is rationally indicated and gives the best results are for the most part included under the divisions of hypertrophies and neoplasms. Its curative effects have also been demonstrated in certain parasitic, glandular, exudative and neurotic diseases. To enumerate a few of the diseases in which the superior efficacy of mechanico-surgical treatment has been demonstrated, may be instanced: acne, angioma, alopecia, callositas, clavus,

carbuncle, condylomata, cornu-cutaneum, elephantiasis arabum, epithelioma, fibroma, furunculosis, hirsuties, keratosis, keloid, leprosy, milium, moles, onychia, perionychia, port wine mark, rodent ulcer, sarcoma, seborrhœa, sebaceous cyst, telangiectasis, ulcers, xanthelasma, etc. \* \* \* \* \*

#### TREATMENT OF LUPUS.

Lupus may be taken as the type of cutaneous disease, the treatment of which most fittingly illustrates the infinite variety and extent of our mechanical and surgical resources, and at the same time exemplifies their incontestable efficacy. Under improved methods of treatment lupus is no longer regarded as an incurable disease; the conditions of successful treatment are that it should be instituted sufficiently early, that it should be energetically carried out and adapted to the particular variety of disease.

Lupus may be defined as a local malady, without general manifestations, slow in its evolution, chronic in its course, and rarely the cause of death, except secondarily from its transformation into epithelioma, or its association with tubercular complications of the internal organs. The question whether the local disease is capable of auto inoculation, and thus prove the starting point of profound visceral lesions, still divides medical opinion. It is generally regarded as a local expression of the scrofulous diathesis, closely analogous to, if not identical with, tuberculosis. At the present day most authorities class it as a tuberculosis of the skin.

Notwithstanding its diathetic relations, experience proves that constitutional treatment signally fails to cure or in any way materially modify the development and course of lupus, while local treatment, judiciously selected and faithfully carried out, is almost invariably successful.

Lupus is pre-eminently a disfiguring disease; it is almost invariably situated upon the face, hands and exposed parts, and the large proportion of its subjects are women. On this account cosmetic considerations should enter largely into the appreciation of the value or availability of any proposed method of treatment.

The object in view is two-fold: 1st, To remove or cause the absorption of the lupus infiltration; 2d, To secure a good cicatrix. Any treatment should be condemned which results in a cicatrix more profound or disfiguring than would have been occasioned by the disease itself. The essential conditions of a good cicatrix are that it should be superficial, smooth, supple



and non-contractile, not restricting the movement of the skin over its subjacent connections and thus destroying the mobility of feature which is so important a factor in the expression of the human face. The vast array of agents and methods which have been employed in the treatment of lupus attests the exceeding obstinacy of this affection, but many of them have a historical rather than a practical interest.

A brief resumé of the various procedures which have been employed is necessary, for purposes of comparison with the methods included under the general head of mechanico-surgical treatment.

The methods in vogue may be classed as follows:

*First.* Irritant substances.

*Second.* Canterization, general or interstitial, by potential caustics, or the actual cautery.

*Third.* Excision en masse, or partially, by raclage.

*Fourth.* Multiple punctures and scarifications, or by a combination of two or more of these methods.

The various emollient and resolvent applications which have been recommended do not enter into the category of curative agents; they must be classed rather as accessories to other treatments.

*Irritant substances* are employed with the view of determining in the diseased tissues an inflammatory reaction, more or less intense. The cutaneous inflammation thus artificially provoked is analogous in its influence to that of erysipelas, temporarily, at least, arresting the lupus process and creating an inflammatory fluxion which favors the resorption of the lupus infiltration. Various chemical agents have been recommended with this view—the energy of whose irritative action varies from that of an active resolvent to that of a profound vesicant; potash soap, iodine in tincture or glycerite, iodoform, iodol, iodide of sulphur, and various acids and mercurial preparations.

*Caustics.*—Destructive cauterization of the lupus tissues may be effected either by potential caustics or by the actual cautery. This destruction may be en masse, by applying the caustic to the entire affected surface, or it may be discrete and interstitial, accomplished either by the introduction of a chemical agent in the tissues, or by linear or punctate cauterization with the thermo-cautery.

The chemical agents most generally employed for the destruction of lupus tissue are arsenic, chloride of zinc, caustic potash, ethylate of sodium, the Vienna paste, Landolfi's paste,

acid nitrate of mercury and various acids, as acetic, carbolic, chromic, lactic, pyrogallie, salicylic acid, etc. The objections to these chemical cauterants are, that the pain is usually severe and prolonged, the depth and extent of the destructive action cannot be accurately limited, the inflammatory reaction is sometimes intense and may proceed to ulceration, and the cicatrices are not as a rule good; moreover, the treatment often fails, and has to be many times repeated.

Unna claims most remarkable curative results from the use of a 25 to 50 per cent. salicylated plaster, to which an equal or double percentage of pure creosote is added to annul the pain. He asserts that the salicylic acid searches out and destroys the lupus nodules as if a punch had been employed. The same elective affinity for lupus tissue is claimed for arsenic and lactic acid; but, according to my observation, this claim is not substantiated by clinical results.

The same objection applies with almost equal force to the actual cautery. While the hot iron is undoubtedly more prompt in its action, and gives a better and more uniform cicatrix, patients are apt to shrink from the application of so formidable an appliance. It is almost always necessary to use an anæsthetic, and recurrences are frequent.

It is to be remembered that within the confines of the lupus patch healthy tissue is interspersed with the lupus infiltration, and when the entire surface is cauterized en masse, destruction of the sound tissues included within this area is inevitable. This objection has been sought to be overcome by the employment of *interstitial and discrete cauterization*. The chemical agent may be introduced into the diseased tissues either by conveying it on the point of the lancet, by acupuncture instruments or the ordinary hypodermic syringe, or by dipping the end of a sharpened stick in carbolic acid, etc., and burning into the lupus nodules. Various chemical agents have been employed for interstitial cauterization, as the perchloride of iron, sulpho-ichthyolate acid, glycerite of iodine (1 to 20), etc.

The same result may be accomplished by boring into the lupus tissues with the solid stick of nitrate of silver, or potassa fusa. Practically, these procedures are found to be slow in action, quite painful, and apt to leave deforming cicatrices.

Unquestionably, the best results from cauterization are effected by what has been termed the method of punctate or linear cauterization with the galvano-cautery.

The treatment of lupus by the galvano-cautery was first prac-

tised by Hebra. This method has been developed and brought into its present state of perfection by Besnier, of Paris. He has devised a number of ingenious instruments in the shape of points and blades and buttons, which are admirably adapted for the object in view. Punctures are made with the galvano caustic needle or button, or scarifications are made with the galvano-caustic knife, which may be single or multiple. A dull or cherry-red heat is generally employed. A white heat is liable to be attended with hemorrhage, and apt to obscure the vision of the operator. The small nodules may be destroyed by a single puncture, lupus patch may be thickly studded or tattooed with punctures, or the entire surface may be gone over with parallel scarifications. The cauterization should extend to the depth and extreme limits of the pathological tissue. Local anæsthesia is rarely necessary. After the operation, the parts are covered with a dry dressing, or a mercurial plaster. The minute eschars separate in the course of a few days, and the operation is repeated in about, say eight days, until every trace of the lupus tissue is destroyed. In lupus of the eyelids, of the conjunctiva, of the buccal, pharyngeal and nasal mucous membranes, the electro-cautery is especially applicable. This method, Besnier characterizes as the most certain means of cure, and the most rapid and inoffensive of all methods that may be applied to local tuberculosis.

*Excision.*—Coming now to what may be termed the bloody methods of treatment, the radical operation of excision will arrest our attention but for a moment. Excision of the lupus infiltration en masse is a method which has been condemned by its bad results, and which is now practically abandoned. It is available only when the lupus is favorably situated, and of limited extent. No matter how freely the excision has been made, lupus nodules often redevelop in the cicatrix or its margin. The principal objection to its use, however, is that it leaves a deep, dense, and contractile cicatrix, which is often more unsightly and deforming than the disease itself.

A modification of this method is that of *raclage* or scraping with the dermal curette, first developed and brought into prominent notice by Volkmann. With the curette all the diseased and softened tissue may be scraped away, while the firm healthy tissues resist its action. After all the lupus granulations are removed, the wound may be treated with iodoform, a weak preparation of pyrogalllic acid, or with the Paquelin cautery. The results of this plan of treatment are not, as a rule, favorable.

It finds its special applicability in lupus of the nasal fossæ and other regions where the methods still to be described are not so available.

*Punctures and Scarifications.*—Finally, there remains to be considered the method of punctures and linear scarifications. The rationale of this treatment is to divide and obliterate the cutaneous capillaries, cutting off the blood supply to the lupus tissues, and thus destroying them by inanition. It also favors the destruction of the neoplasm, by hastening the elimination of the degenerated lupus cells, and modifying the nutrition of the embryonic tissues, so that they contribute to the formation of the connective tissue which constitutes the cicatrix.

Dubini, in 1868, was the first to employ multiple punctures, using a sharp-pointed instrument. These punctures were not relied upon as a curative means, but were preliminary to the introduction of chemical agents.

The method of linear scarifications was introduced by Ballanno Squire. The incisions were closely approximated, and two or three days later crossed by another series of incisions, the surfaces were cauterized by a solution of chloride of zinc in alcohol. Squire employed a multiple scarificator, the blades arranged parallel to each other. This instrument is valuable and most convenient in lupus erythematosus, but in lupus vulgaris, when there is not a uniformly distributed mass of infiltration, the single blade is far preferable, since it is not desired to lacerate the healthy tissues to the same degree as the lupus nodules themselves.

To Vidal, of Paris, is due the credit of developing and perfecting this method, of devising certain improved instruments, of modifying and adapting it to meet the indications of each particular case, and of demonstrating the value of its application, not only in the treatment of lupus, but in various other cutaneous affections.

[The readers of this JOURNAL have already been made familiar with the peculiarities and advantages of the method of quadrilateral linear scarifications, through the admirable letter of its Paris correspondent (March number). Dr. Brocq has described this method and precised its indications with such circumstantiality and minuteness of detail that, to avoid repetition, the portion of this paper referring to linear scarifications is omitted.]

After this rapid glance at the various procedures employed in the treatment of lupus, we come now to an appreciation of

their relative value based upon their results, both from a curative and cosmetic point of view. Certain objections to the use of potential caustics, the Paquelin cautery, excision and racleage, have already been referred to in connection with the description of these methods.

The method of punctate and linear galvano-cauterizations developed by Besnier and the method of linear scarifications perfected by Vidal, I regard as the most important advances yet made in the treatment of this obstinate and disfiguring disease. From a cosmetic point of view, the results of Vidal's method are incontestably superior. The cicatrix is more superficial, more uniform and supple, and more nearly approaches the normal skin in appearance and texture and is not so apt to be the seat of keloid. On this account this method is alway to be preferred in the treatment of lupus situated upon the face, neck or exposed parts ; on covered parts an unsightly cicatrix is less objectionable.

In some cases, as for example, in lupus of the mucous membranes, or occurring in the form of isolated tubercles, the ingenious instruments of Besnier are to be preferred. Each method finds its special application according to the form, character and situation of the lupus ; under certain conditions a combination of the two methods gives better results than either alone.

It is a mistake to assume that any one plan of treatment is the best in all varieties and stages of lupus. Thus, for example, when the disease is in process of cure and isolated nodules redevelop in the cicatrix and are manifest as minute pin-head sized yellowish spots, they may be promptly destroyed by the pyramidal double-threaded screw devised by Malcolm Morris, which is inserted into the nodule and twisted round and round, until the morbid infiltrate is broken up and destroyed. For the same purpose Fox has recommended the use of certain minute instruments used in dental practice and known as the dental burr or hook, this is inserted subcutaneously and by a series of rapid revolutions the nodule is broken up with the least possible injury to the epidermal covering. In conclusion I may say one word in regard to my personal experience in the treatment of lupus by linear scarifications.

In common with most dermatologists in this country, I have been for a long time familiar with this method and have had considerable experience in its application ; I was never, however, so impressed with its superiority until after a prolonged observation of its results, extending over a period of several weeks dur-

ing the past summer at the Hospital St. Louis, in Paris. Every week Vidal operated on a large number of patients representing every variety of lupus. In his practiced hands the results were so surprising and satisfactory that I recognized the fact that my own failures were due not to any essential defect in the method, but to deficiencies in technique and lack of efficient and thorough application. This method, in order to accomplish the best results of which it is capable, must be carried out patiently, perseveringly and with an attention to minute details which can only be gained by a long practical experience. It must be modified to meet the indications of the particular variety of lupus and combined, in certain conditions, with other methods.

Within the past six months I have employed Vidal's improved method in a number of cases with the most satisfactory results; I have seldom found it necessary to resort to local anæsthesia. At least two of my patients who had been previously treated by other physicians with pyrogallic and salicylated plasters for several months, and unsuccessfully, have assured me that the momentary pain from the scarification is nothing in comparison with the prolonged suffering caused by the irritant plasters. After the operation, the surface is sprayed with the dilute tincture of calendula instead of the bichloride solution. The accessory treatment subsequent to and in the intervals of the operations I regard as of great importance in facilitating the cure. For this purpose I have experimented with a number of preparations in addition to the emplastrum hydrarg. and the red cinnabar plaster; the latter, however, I have found the least irritating, and quite as efficient in promoting resolutions of the neoplastic tissue.

#### DISCUSSION ON LUPUS, IN THE SURGICAL SECTION OF THE NEW YORK STATE MEDICAL SOCIETY.

DR. HENRY G. PIFFARD, of New York, read notes on the use of hydronaphthol in the treatment of lupus. He stated that he had always practised very vigorous treatment in lupus, but in some cases it was necessary to employ milder means, such as carbolic acid, green soap and bichloride of mercury. But none of these agents had been satisfactory. During the last ten months he had treated six cases by local applications of hydronaphthol, in five cases there was no relapse, the other relapsing frequently, as certain cases of lupus will after any treatment. The drug was employed in a ten per cent. solution in liquid gutta percha, applied daily for a week or more, when a crust formed which was allowed to remain until it fell spontaneously. This treatment was repeated three or four times.

He had also used the drug in a twenty per cent. rubber plaster, which was applied and allowed to remain for a week, when it was necessary to renew it. He had been very much pleased with the results.

DR. GEORGE H. FOX, of New York, said that for the successful treatment of lupus, complete removal of the diseased tissue was necessary. But in extensive patches the scars were likely to be very disfiguring, if any method of treatment was adopted which left a large ulcerating surface to heal by granulation; therefore, excision and the actual cautery and the curette must be avoided in such cases. Scarification was far preferable to the other methods of treatment just enumerated for these extensive patches. It also enables the operator to destroy minute points of infiltration, which could not be destroyed by any other means. But even better than scarification for these very small deposits, was a drilling out with an instrument resembling a dentist's burr drill. This could be made to operate subcutaneously, to a certain extent, in cases where the growth beneath the skin was more extensive than in the skin itself.

He had used hydronaphthol in rubber plaster, as recommended by the previous speaker, and had found it excellent. Even better results were obtained from an ointment, containing the sulph-oleate of soda, which was miscible with water.

DR. PIFFARD remarked that he could not agree with all the statements made by the reader of the paper. Excision was by all means the most suitable treatment for small deposits of lupus, just as much as for small epitheliomatous growths. Scarifications, both linear and punctate, as well as curetting and the actual cautery, were not so effective in the treatment of lupus, and required frequent repetition. As to the cautery, he had found that a white heat was necessary to reach anything beyond the surface, and the hemorrhage was usually slight. But even cautery at a white heat was too superficial in its action, and was suitable only after thorough use of the curette, and he considered the solid stick of nitrate of silver as good as the actual cautery. For very large patches, of an extent larger than a silver quarter of a dollar, scarification was a suitable operative treatment, but he had found that the absorptive action of hydronaphthol was as effective. Some cases resisted all treatment.

DR. SHERWELL, of Kings County, agreed with the last speaker as to his choice of methods. He had not tried hydronaphthol, but proposed to do so. He had in some cases been very well satisfied with the results of treatment by local applications of pyrogallol, followed by mercurial plaster.

DR. MORROW closed the discussion, remarking that he thought no agent would ever be found which would have an elective affinity for lupus tissue. The same selective action had been

claimed for pyrogallol, arsenic, lactic acid, as for hydronaphthol, but their claims had not been confirmed by a more extended clinical experience. He desired to reiterate his statement, that the pain produced by scarification was only momentary, and far less than that caused by active caustics.

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## Society Transactions.

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### THE NEW YORK DERMATOLOGICAL SOCIETY.

#### THE 179TH REGULAR MEETING.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. FOX presented a case of

#### DIFFUSE CARCINOMATOUS INFILTRATION OF THE SKIN.

The patient's breast had been extirpated for carcinoma, and the recurrence of the disease occurred in the form of diffuse infiltration, which occupied the breast, abdomen and upper portion of thighs. The woman was well nourished, and seemed to enjoy good health. There was no cachexia.

In the discussion, DR. SHERWELL said that in his opinion the diagnosis was correct, yet he thought that there was a possibility of a lymphadenoma being also present, perhaps conjoined to the original carcinoma.

DR. ALLEN also concurred in the diagnosis. He thought that the term cancer *en cuirasse* would not in this case be an applicable one, since the disease extended down on the legs.

DR. BRONSON did not think that all the symptoms present were due to carcinoma alone, but there were some lymphatic changes associated with them. In portions, the tissue was diffusely brawny, seeming to be between carcinomatous infiltration and lymphatic engorgement. He also thought that there should be some evidences of cachexia, if the entire disease was carcinoma.

DR. ROBINSON agreed with the diagnosis, but thought the case showed directly the opposite of what Dr. Bronson held. He did not think that there was such a thing as a cancer cachexia, but the symptoms to which that term was applicable, did not appear until the cells began breaking down. The cachexia was not the result of the cancer itself, but of the cellular destruction caused by it.

DR. ELLIOT said that he regarded the case as carcinoma. In regard to the absence of cachexia, he did not think that was against cancer, but only showed that metastasis had not yet taken place. As far as the causation of cancer cachexia was concerned, he would agree with Dr. Robinson that it was due to cellular destruction.

DR. FOX, in summing up, stated how often it was supposed that the cachexia was the cause of cancer, instead of vice versa. He had seen many cases of recurrence in those affected with cancer, but only one other besides the patient presented to the Society, in which the disease had involved so much tissue.

DR. ELLIOT presented for Dr. Bulkley a case of

#### DERMATITIS HERPETIFORMIS.

S. A., age 26, policeman, entered the New York Skin and Cancer Hos-



pital in Dr. Bulkley's services, February 19, 1888. He states that the eruption began some eight months ago upon the back. It is now situated upon that surface, but more especially over extremities. The chest is free. Only a few on abdomen, face and neck. The lesions consist of groups of small vesicles upon a slightly elevated and reddened base. The affection comes out in successive crops, is intensely itchy, causing continual scratching. There is considerable eczema present.

DR. SHERWELL, in discussing the case, said that, in his opinion, sugar would be found in the urine in a number of these cases of herpetic eruption. He had had several in which that feature was present.

DR. ALLEN said that the case reminded him very much of one which was in Charity Hospital, and which had been several times diagnosed as prurigo. There were also some vesicles present. He had found that the patient had a tight prepuce, and he had operated on him, performing circumcision. The eruption had disappeared after this without treatment, but a few days ago a new eruption of papules, vesicles and pustules had occurred. He would consider the case shown to-night as dermatitis herpetiformis.

DR. FOX said that he had lately had two cases of bullous disease under treatment. In one of them, no sugar was found; in the other, a typical pemphigus vulgaris, sugar was present. Under change of diet, the bullae disappeared, and the prognosis, which at first was unfavorable, is now good, the patient's general condition being very satisfactory.

DR. SHERWELL recommended that the urine be examined more than once, as sugar might be absent at times, but present at others.

DR. ELLIOT presented a case of

#### ECZEMA MARGINATUM.

F. L., age 32, presented himself for treatment, on February 22, 1888. He stated that the disease began two years ago, on the inner surface of the thighs, near Poupert's ligament. From thence it progressed slowly, and, being accompanied by severe itching, he applied sulphur and borax. As a result of this treatment, the disease had disappeared from the left thigh, the portions which had been affected being now white and unpigmented, in strong contrast to the rest of the skin, which is of a decided brunette color. At present there is found on the right thigh, anteriorly, a large lesion in shape like a figure eight, resulting from two rings, which have coalesced. Posteriorly are two other circinate lesions of large size. The borders of these are narrow, sharply defined and slightly elevated, their centres are infiltrated, scaly, and with small crusts here and there. The anal furrow, from the coccyx to the perineum, is bounded on both sides by a gyrate, more or less continuous red, elevated, sharply defined border, which encloses a scaly, macerated and infiltrated surface. The itching is intense.

DR. BRONSON, in discussing the case, said that he had had the same patient under treatment two months ago. At that time the marginate characteristics were more defined. He had treated the patient with chrysarobin, boric acid and sulphur, and hydrargyrum bichloridum. The eruption had improved a good deal, but the irregularity in attendance of the patient had occasioned very slow and unsatisfactory results.

DR. FOX referred to the contagiousness of eczema marginatum. He had lately had under his treatment three brothers in one family and two in another, who all had this same affection. He had found that in the latter family, the second brother had slept in the same bed in which the first one affected had slept—not with him, but after him—and thereafter developed

the disease. He had obtained the best results in treatment with resorcin 20 per cent.

DR. ELLIOT in summing up, said that he was glad to hear from Dr. Bronson that the patient had been treated with bichloride of mercury, because he had been puzzled to explain the removal of the pigment by means of sulphur and borax, as described by the patient.

DR. ELLIOT presented a case of

#### LUPUS VULGARIS NASI.

The patient was a healthy German woman, forty-eight years of age. There was absolutely nothing in her history which pointed to syphilis. She was married, had three healthy children, had had no miscarriages, no previous diseases of the skin or eruptions of any kind. The affection began in August 1886, on the left ala nasi and has extended from thence upwards to the middle of the nose, and over on the cheek to just below the inferior border of the orbit, and, also, implicates at present the entire end of the nose and two-thirds of the right ala. The affected surface is soft, without any induration, is diffusely occupied by the disease, is painless. The tissue is markedly red; the small, brownish-red tubercles, characteristic of the disease, do not occur discretely, but in a diffuse form, and upon these portions slight pressure causes the penetration into the tissue of a silver probe or of a stick of nitrate of silver. Over the entire surface the epidermis is slightly scaly, and on the under surface of the nose are seen scars, where nodules have undergone destruction and been replaced by cicatrices.

DR. SHERWELL, in discussing the case, said that this patient furnished a good example of the erroneous dictum that lupus always began in early life. It was not a rare thing to meet the disease beginning after middle life, and he could remember several such cases.

DR. FOX stated that in his opinion the history of the late age at which the disease commenced, and its extensive development in one and a half years would point to syphilis.

DR. BRONSON agreed with Dr. Fox. The history of the case and its clinical appearances resembled syphilis more than lupus. The changes on the left ala, he thought, spoke for syphilis, as, also, its rapid progress, so much tissue being involved in so short a space of time.

DR. ROBINSON did not think that it was possible to make an immediate diagnosis. He was inclined to lupus, but had not seen any resorption tubercles such as he would expect if it was a lupus.

DR. ELLIOT, in summing up, said that he could not see how there could be any question in regard to the nature of the process. The symptoms characteristic for lupus were present—the soft, brownish tuberculous infiltration, which could be penetrated with the greatest ease by a probe or stick of nitrate of silver and the diffuse development and implication of the tissue by the disease. He could not regard it as syphilis, for if it was that disease it would have to be a late manifestation of that affection, and as such would follow the course of late syphilides. That is, there would be a grouped eruption, which in a year and a half would have undergone a serpiginous development, leaving characteristic symptoms on the ground over which it had traversed; there would have been ulceration, and, at any rate, the peculiar infiltration of syphilitic lesions would be observed. Instead, however, of these there was an entire absence of even a remote syphilitic history—no grouping, no ulceration, no serpiginous development, no infiltration. Dr. Elliot was willing to leave the decision to the microscope, notwithstanding

that he was convinced that the disease was lupus, and would examine particularly for tubercle bacilli. If their presence were demonstrated, he thought that there could then be no more question in regard to the case. At Dr. Fox's suggestion he would place the patient upon mixed treatment.

DR. TAYLOR stated that if the case was one of syphilis the chances that small ulcers would be present were 90 in a 100.

DR. SHERWELL presented for diagnosis an

ULCER ON POSTERIOR PORTION OF LEFT THIGH.

The disease had begun about twelve months ago as a slightly reddened, itchy and thickened spot. He had consulted a physician about four months ago, who had prescribed a lotion. Shortly after it began to look like a boil, which a week or so later ulcerated and grew larger. Since then poultices and unzt. zinci. oxidi. has been used. The ulceration is now perfectly circular, about one and a half inches in diameter, the edges are elastic, quite well defined, not hard and dense. The base is uneven, quite deep, and more or less covered with débris.

DR. FOX stated that he thought the case was one of epithelioma.

DR. ROBINSON thought that the diagnosis lay between epithelioma and sarcoma.

DR. KLOTZ preferred to regard the lesion at present as a simple maltreated wound, and though he would not say it was not malignant, yet would advise its treatment to be that of a simple ulcer.

DR. ELLIOT stated that he would regard the lesion as a carcinoma cutis. He had seen an identical ulceration in a case some time ago. This had been excised, and under the microscope was found to be carcinoma.

DR. SHERWELL said that at present he was in favor of regarding the affection as a malignant one. There was not the everted border which one would expect in epithelioma, but an infiltrated one, and he thought the lesion was sarcoma. He intended, however, to treat it as a simple ulcer. He had seen lesions malignant in appearance, which, treated with sulphur and such agents, had healed. He had within the last twenty-four hours used a mild lotion, and the ulceration had a better appearance.

DR. FOX recommended the use of a 10 to 20 per cent. hydronaphthol plaster.

DR. PIFFARD presented a case of

ICHTHYOSIS SIMPLEX.<sup>1</sup>

DR. SHERWELL presented a case for diagnosis, of

ERUPTION ON FACE. LUPUS VULGARIS, OR NÆVUS PIGMENTOSUS.

The patient, age 15, has a number of small lesions, slightly elevated, reddish brown in color, situated on cheeks, sides of nose and chin. Those on chin have developed lately; the others, which have increased in size, have been present, according to the boy's parents, ever since birth.

DR. ALLEN, in discussing the case, said that he regarded it as one of nævus fibrosus.

DR. FOX held it to be a fibro-vascular nævus.

DR. BRONSON thought it was a nerve nævus.

DR. CUTLER believed it to be a simple nævus.

DR. SHERWELL, in summing up, said that he considered it to be a

<sup>1</sup> The description of this case formed candidate's thesis presented at meeting.

nævus. He thought he would treat it with the dental burr recommended by Dr. Fox, and then cauterize afterwards.

DR. JACKSON recommended electrolysis with a large needle.

DR. FOX presented a case of

ERYTHEMA ANNULATUM.

The patient, a boy, showed characteristic lesions on the extremities and face. In some of the circles a vesicle had developed, constituting an erythema iris.

DR. ROBINSON presented a case of

LUPUS ERYTHEMATOSUS OF THE SCALP,

stating that it was the same case which had been presented to the Society four years ago. No diagnosis had been made at the time, the opinions in regard to the case being divided between eczema and syphilis.

DR. FOX remembered seeing a similar case, in which the eruption occurred on scalp and left cicatrices like those on this patient.

DR. BRONSON mentioned a case, which had also been seen by Dr. Allen, in which the scalp and no other place had been affected. The patient had also in addition an eczema on the body.

DR. ROBINSON stated that he presented the case only because it had been seen by the Society four years ago, and the diagnosis was not made by the members.

DR. FOX then showed some photographs, and asked if any of the gentlemen present recognized such a disease as chronic erythema multiforme. He had met with two or three cases of erythema multiforme, which were chronic in their course. In the case, the photograph of which he showed, the eruption consisted of raised rings with bullæ on the edges. Every three or four weeks the patient has a return of these rings. Dr. Fox also mentioned a case which occurred in a woman. In this one the erythematous rings would run together, and, traveling over the surface of the skin, finally end in desquamation.

DR. KLOTZ spoke of a case of erythema circinatum in a patient who had syphilis. The eruption recurred periodically every three weeks under the form of red rings. At first, he thought it was the result of the syphilis, but on close inquiry it was ascertained that the lesions had made their appearance before syphilis had been contracted.

DR. BRONSON spoke of a case occurring in a dyspeptic young woman. It was not so persistent as that mentioned by Dr. Klotz, but still chronic. It was not exactly an erythema, but more like the so-called giant urticaria, except that there were no wheals. The lesions would make their appearance suddenly in the form of nodes, about the size of a pigeon's egg. They occurred on the face, head and body.

DR. TAYLOR believed it to be the same form of erythema, as described by some, to be of neurotic origin. He knew of some cases in which erythema occurs after taking quinia, iodide of potash or belladonna. He had also seen erythema resulting from copaiba in which the lesions were annular. He asked if there was anything in the cases quoted, which would do away with the idea that erythema multiforme was apt to recur.

DR. KLOTZ said that in his case the eruption was apt to recur after emotion or excitement. He had at first thought it might be due to calomel injections for the treatment of the syphilis, but he had found that this was not the case.

DR. TAYLOR spoke of a case in which two drops of the tinct. belladonna given for sore throat, had produced erythema.

DR. BRONSON showed a preparation of *sapo unguinosus* of Dietrich, which had been mentioned in the *Monatshefte f. prak. Dermatologie* in 1887. The preparation shown, contained mercury. It was claimed that it was more readily absorbed than ordinary ointments and was cleaner.

DR. FOX thought that the sulpho-oleate of soda was a better menstruum and that it was more readily absorbed, but not so bland as some ointments. In consequence it was not well adapted to inflamed surfaces as in acute eczemas.

DR. ROBINSON showed a drawing of an eruption which occurred in a child with pneumonia. The lesion appeared on the hands, feet and mucous surfaces of mouth, commencing as bullæ, which were more or less grouped, and which finally became pustular. The eruption lasted ten days.

DR. ROBINSON also showed a drawing of a case of *nævus unius lateralis*.

DR. TAYLOR spoke of a bullous pemphigoid eruption, occurring in a child with pneumonia. It ran a peculiar course, the contents of the bullæ becoming inspissated, so that they could be dug out.

The Society then went into Executive Session.

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## Correspondence.

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### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

The Surgical Treatment of Skin Diseases at the St. Louis Hospital in Paris, and Particularly by the Method of Scarification.

(Concluded.)

#### Treatment of Erythematous Lupus.

IN my preceding letter I have told you of the principle, and also described the method of carrying out linear quadrilateral scarifications, and its application to the different varieties of tubercular lupus. To-day I shall consider the other dermatoses in which it may be useful. True, superficial erythematous lupus which spreads over extensive surfaces is much less easy to treat by scarifications than tubercular lupus. Besides, all dermatologists know how rebellious and capricious this affection is. Vidal does not always and in all cases of lupus erythematous advise linear quadrilateral scarifications; and thinks that at times it is well to employ other means. I have shown in one of my memoirs that, in order to overcome this affection we ought to change the method of treatment as soon as the procedure employed no longer seems to produce a good effect. Then we ought to try successively either applications of black soap, salicylic acid plaster or paste. Vigo plaster, pyrogallol in collodion, salicylic acid in collodion, which I have myself employed with certain success in 1886 and 1887, at the St. Louis Hospital, or acetic or pyroligneous acid, and finally scarifications. These latter may be made quite superficially at a depth of a millimeter and a half or two millimeters, as regularly rectangular and as near to each other as possible; scarcely a millimeter apart. I have succeeded, in some cases, in making them less than a millimeter from each other. Crossing them once is sufficient. When two extensive surfaces are to be scarified, the multiple scarifier, with sixteen blades of Balmano Squire may be employed. This shortens,

very much, the time necessary for the operation. I think, however, it is preferable, when possible, to use the single-bladed scarifier of Vidal with which the operation is much better regulated. In the same way as in tubercular lupus in erythemato-acneiform lupus, of which we shall speak, we must, first of all, attack the limits of the disease, and even go beyond the borders to prevent an extension of the neoplasm. The consecutive treatment is the same for all forms of lupus, and I shall not refer to it again. There is another variety of lupus which most authors consider closely allied to the preceding forms, but which differs from them, however, by its evolution and in its appearance. It is the form which we call in France *lupus erythemato-acnéique* (the *lupus acnéique* of Bazin, or *lupus erythemato-discoïdes* of Kaposi). The lesions, in these cases, extend very deep, infiltrating the whole, or nearly the whole, thickness of the derma. In some rebellious cases they infiltrate the subcutaneous cellular tissue as well, as Vidal and Leloir have verified in their histological researches, forming a sort of hard resisting cake. This lupus is the most difficult to treat. The zone of disease is not extensive, but it is deeply penetrating. Here the scarifications must be short, but very deep, very close to each other, and must be crossed in two, three, or even four different directions, if possible, and extend to the limits of the derma. In carrying out this plan of treatment the lesions can be destroyed, but without it they are constantly reproduced from the deeper layers.

#### **Advantages and Inconveniences of the Treatment of Lupus by Quadrilateral Linear Scarifications.**

We have already shown the principal advantages of this method in the treatment of lupus. It is now possible, thanks to this method, to surely arrest the destructive march of lupus vorax, and to prevent all the horrible mutilations consequent upon it, and to cure most forms of lupus without leaving vicious cicatrices.

The inconveniences, are some real, and others still open to discussion. Among the real inconveniences I will mention, 1st, Pain ; but we have seen that, if it be hard to bear, it can be lessened, or entirely done away with, by the use of cocaine, or the chloride of methyl. 2nd, Hemorrhage ; but this hemorrhage, which is never very abundant, and only takes place once a week, can be reduced to a minimum by the exercise of a little care, and is so slight that the operation can be undertaken even in debilitated subjects. 3d, The *slowness of cure, and the necessity of frequent operation* is the principal objection, and we know that in certain particularly rebellious cases it is a valid one.

We are not so exclusive as not to be the first to recommend other therapeutic measures, as soon as it is seen that multiple linear scarifications do not any longer give noticeable good results. We even prefer for most cases of lupus of the limbs and body, cauterizations with the galvano cautery, or the thermo-cautery or scraping, but for lupus of the face where it is so important to secure a really good cicatrix, we are convinced that we must first, and always, choose linear quadrilateral scarifications. I should add that there are physicians in France, at the head of whom Besnier must be placed, who consider the method of quadrilateral linear scarifications as eminently dangerous in lupus, and advise that it should never be employed in this affection. These fears are based on the opinion firmly held, that all

the varieties of lupus are cases of cutaneous tuberculosis, and on the possibility that the bacilli contained in the lupus neoplasms may penetrate into the vessels widely opened by the scarifications, and be carried away to infect the whole economy, and that thus we favor the transformation of tuberculosis, which is, as yet, only external and localized in the integument into an infectious, and visceral tuberculosis. Dr. Besnier has noticed that several lupus patients whom he had himself scarified, or who has been scarified by other physicians, rapidly developed pulmonary tuberculosis. I cannot here enter upon the question whether or not lupus is a cutaneous tuberculosis. It is beyond doubt at the present day, that many lesions formerly called lupus, are, in reality, varieties of tuberculosis of the skin ; but, are all the cases formerly called lupus, particularly the true lupus erythematosus, instances of cutaneous tuberculosis ? This is a question which is still obscure and difficult, though in part cleared up. However it may be, I must leave it aside, and occupy myself with the question in hand. Does scarification favor general tuberculous infection in lupus cases ? Despite the great authority I recognize in Dr. Besnier, and the profound respect I have for my excellent master, I acknowledge myself not yet convinced. I have already observed many lupus patients treated by scarification since I have either seen, or myself taken care of nearly all the patients treated by Dr. Vidal since 1881. I have found in certain of these cases, pulmonary tuberculosis, or have discovered the glands or joints affected, but these symptoms in nearly all the cases, existed in some degree before scarifications were begun.

In private practice I have observed but a single accident in the patients I have scarified. This was in the case of a large robust woman of twenty-eight, who had all the appearances of good health, excepting that she had erythematosus lupus of both breasts. After several applications of black soap, I cured these lesions completely by linear scarifications, made very close to each other, in ten sittings. A year later, this woman presented a cervical adenitis of the left side, which she treated by all kinds of irritating applications, until it suppurated. It was then cured by injections of iodoform in ether. At the present time she is well. I have never seen inoculation of the adjacent tissues to a lupus treated by scarifications. Instead of extending in these cases, as it should if incisions favored the dissemination of bacilli, the border recedes. I believe, however, that until we have more light thrown upon this delicate question, the fears formulated by Dr. Besnier should make us more circumspect, and induce us to employ the hot iron where this method offers proper cicatrices. I now associate this method with scarifications within certain limits compatible with good final results, but I acknowledge that I do not yet hesitate to employ scarifications where I judge them useful, efficacious and necessary to cure without deformity. All these provisos are evidently unnecessary in the affections which we will now consider.

#### **Treatment of Seborrhœa Oleosa by Scarifications.**

All dermatologists know how rebellious to treatment is the disease known by the name of seborrhœa oleosa, in which the forehead, the cheeks, and especially the nose, are red, covered with an oily secretion, and somewhat swollen by hyperæmia of the sebaceous glands, of which the dilated orifices can be seen. Dr. Vidal had conceived in the idea of causing atrophy little by little, of the glandular element by scarification. For this purpose it

is necessary to make the incisions as long as possible, quite close together ; about a millimetre, or about a millimetre and a half, apart, and of about the same depth, or even deeper, according to the thickness of the derma, which, however, must never be divided entirely. Sitzings are repeated every five or six days, or regularly every week. From ten to thirty are necessary, according to the case, to secure a good result. Furthermore, lotions of weak boric acid may be used morning and evening. The second and third day a light coating of Price's glycerine may be applied to hasten the falling of the little crusts.

#### Treatment of Rosacea.

Long since, the vascular nature of rosacea, in which the capillaries at times reach an enormous degree of dilatation, suggested the idea of treatment by incising the vessels at several different points, in order to cause their disappearance. Bazin and Westerton first cut the vessels, and then cauterized them with the perchloride of iron. Hebra, of Vienna, had a little instrument made with a triangular point, and a guard which prevented its too deep penetration (*Stichelnadel*). He employed it to make punctured scarifications of the surfaces attacked with rosacea. Dr. Vidal uses it also in certain cases, especially in sycosis, and in indurations of limited extent but deeply penetrating, complicated with intradermic abscesses. When these infiltrations are punctured in multiple points, they are indeed seen to be rapidly absorbed. Nothing can, however, be compared as regard the efficacy of treatment in rosacea of a marked type with linear quadrilateral scarifications. They should be made in a regular manner, at a millimeter or a millimeter and a half apart, quite long and deep enough to cut across the dilated and varicose vessels. If we have a hypertrophic acne to deal with, it can as well be modified for the better by this procedure, but here the derma must be incised in nearly its whole thickness, but without reaching the subcutaneous cellular tissue, and much less the cartilage, so as not to leave visible cicatrices; and in this we are not guided, as in lupus, by the softness of the morbid tissue. Here again, as in lupus, it must not be thought that we treat all cases of rosacea by this method. We only treat in this way at first those cases in which the dilatation is too far advanced, and the vessels too numerous for us to hope for any results from other means ; otherwise we resort to other well-known forms of medication or alternate with linear scarifications. These latter may also be employed to cause the last traces of the disease and the varicosities to disappear, which, without this powerful intervention, would persist too long, if not permanently.

#### Treatment of Telangiectasis and Nævus Vascularis.

What I have just said of varicose rosacea applies equally well to telangiectasis. As early as 1876, Dr. Balmano Squire suggested linear scarifications for the treatment of *nævus vascularis planus*. This English author appreciated the fact, that the erectile forms of *nævi* are not capable of being treated by this method, but he advised it for the variety which we have named, and obtained cures. We are somewhat less affirmative in France in respect to this disease. We know that after many repetitions of the scarifications we can obtain benefit up to a certain point, and can lessen the coloration of *nævi* of limited extent, but those of vast extent are rebellious to treatment.

We see as the number of operations increase, that the skin becomes



hardened and assumes a less pronounced color. In spite of numerous trials, repeated with great perseverance, Dr. Vidal has not yet been able to obtain complete and lasting cures. After a few months, the vinous coloration tends to reappear. Even the trials made with the oblique bladed scarifier of Balmano Squire have not given better results. Indeed for this deformity of the skin, scarifications seem to be less commendable than vaccination, caustics, and especially electro-cauterization and electrolysis.

#### **Sycosis and Impetigo Sycosiforme.**

In certain cases of folliculitis of the beard, whether of parasitic origin or not, indurations more or less marked, are seen to form, which in some cases become so voluminous as to form veritable tumors of the skin. These lesions to which long ago the name *Sycosis* was given, disappear rapidly when attacked, according to the rules which we have given for punctured or linear scarifications. It is well to make subsequent applications just as in lupus of vigo plaster or red plaster. There is still another extremely rebellious affection consecutive to chronic coryza in certain persons, or following eczema of the nose or of the upper lip, which consists in an enormous hypertrophy of the upper lip, occasionally producing a partial obstruction of the nostril. This is what is called by the rather faulty name of *Impetigo Sycosiforme* or *Eczema Sycosiforme* of the upper lip. Dr. Vidal has had the happy idea to treat this condition, by quadrilateral scarification. The incisions should here be made at about 2 or 3 centimeters apart, but very deep involving the whole thickness of the skin, and even reaching a depth of from 6 to 9 millimeters. Care must always be taken to cut the whole thickness of the derma to permit of union by first intention to take place.

#### **Treatment of Keloid and Cicatrices.**

I have already told you in one of my previous letters about the treatment of keloid by scarification, one of the most ingenious applications which Dr. Vidal has made of his method, so I will be quite brief at present.

It usually suffices to scarify a few times to render painless a painful keloid. It is well-known that certain of these morbid growths are the site of such hyperæsthesia that the patients can not even bear the contact of clothing. To cause diminution in the volume of a keloid it must be divided in the whole, or nearly the whole, of its thickness, by incisions quite widely separated. Dr. Vidal, after having tried incisions near to each other, now separates them by three or four millimeters. These first are crossed by a second series of equal length and depth. I believe, after numerous scarifications in keloid and cicatrices, which I have myself made, that the distance of the incisions from each other should be proportionate to the thickness of the growth and the depth of the incisions. If the keloid be very thick, and the incisions very deep, they should be 8 millimeters apart, at least. If the keloid be less thick they should be so much the less separated. According as the keloid diminishes under the influence of treatment, the depth of the incisions, and their distance apart should be diminished. In the intervals of sittings it is well to cover the scarified keloid with Vigo plaster, thus, I believe, greatly increasing the activity of the process of retrogression which takes place. This procedure is that which gives by far the best results in the treatment of keloid. I think that in certain cases a real advantage can be gained by combining the treatment with electrolysis. Keloidal Acne, which you call in America *Dermatitis Papillaris*

*Capillitii*, is equally quite rapidly cured by scarifications and the application of Vigo plaster. Finally, I will add that all vicious cicatrices, seem to me to be benefited by linear quadrilateral scarifications. I have said in one of my preceding memoirs that the first woman in whom I removed a full beard (9,000 hairs), had vicious cicatrices for various reasons, partly from her own fault and partly because I did not then know how to use the electrolytic needle as I now use it. These cicatrices were of two kinds, some were real keloidal tumors, varying in size from that of the head of a large pin to that of a large cherry stone, others were diminutive, and consisted in small white blemishes the size of a small pin head, or formed little depressions. I began by causing a disappearance of keloidal scars by alternate applications of electrolysis and scarification carried out as above described. This result once obtained the patient desired me to cause the other traces to disappear; that is the white spots and depressions. I therefore covered all the places which presented lesions with incisions extremely fine, and a millimeter to a millimeter and a half in depth, very close together; not over a millimeter apart and quadrilateral. I had the satisfaction to see the condition of the skin improve with the greatest rapidity. At the present time the face of this young girl is in a very satisfactory condition.

We must then, when we have to deal with superficial cicatrices, make superficial incisions and close together. It is always well in these cases to apply Vigo plaster in the intervals of scarification.

#### **Treatment of Dermatomyoma.**

Are dermatomyoma, like keloid, susceptible to scarifications? The question is still being investigated. All that I can at the present time say is, that Dr. Vidal, who has had no good results from the electrolysis needle, has seen these tumors diminish after several applications of scarification.

#### **Treatment of Chronic Eczema, Pachydermia, Elephantiasis and Cutaneous Ulcers.**

In cases of old chronic eczema, accompanied by thickening of the skin, and sometimes by pachydermia, either smooth or warty, in cases of cutaneous ulcer, in which the borders are very thick, hard and elevated, scarifications offer an excellent adjuvant to the ordinary therapeutic methods. Scarifications facilitate the disappearance of the infiltration, and render the parts supple. It is the same in true elephantiasis; at least, this is affirmed by Le Dentu, of the St. Louis Hospital, who last month made a communication on this subject to the Surgical Society.

#### **Treatment of Rebellious Pruritus.**

Dr. Vidal has had the idea in certain cases of rebellious pruritus of the scrotum, in which all the ordinary means of treatment had failed, to make long parallel incisions in a quadrilateral manner with Balmano Squire's sixteen-headed scarificator, and has thus obtained real benefit. Thus this eminent professor of the St. Louis Hospital, has created a veritable method of treatment of skin diseases which permits us to triumph over certain cases with comparative ease, which were formerly rebellious to other procedures. It also has the great advantage of being a method of treatment which any physician can employ, as it does not necessitate the possession of costly apparatus, difficult to keep in order, or the carrying out of complicated manipulations.

L. BROCCQ.

PARIS.

## Selections.

### ONE HUNDRED OPERATIONS FOR STONE WITHOUT A DEATH.

SURGEON-MAJOR FREYER, of the Bengal Medical Service, reports in the *British Medical Journal* of December 24, 1887, a series of 100 cases of stone in the bladder, operated upon by himself between January 1, 1886, and August 5, 1887, without a death. The list included :

Litholapaxies in adult males. ....	61
Litholapaxies in male children.....	16
Lithotomies " " " .....	22
Suprapubic Cystotomy in a male.....	1

Total, 100

These were the only cases of stone treated by the author during this period.

In sixteen instances of litholapaxy in children, the ages ranged from three and a half to fifteen years. Heretofore the author has advocated lithotomy in such cases in preference to the former operation, basing his opposition on the undeveloped condition of the genito-urinary organs, and the fact that lithotomy has always been recognized as a comparatively successful operation in children. Litholapaxy was attempted in all of the thirty-seven cases of children operated upon, and only after failing to pass a lithotrite was lithotomy done instead. He attributes the large proportion of cases in which litholapaxy was not feasible, to the fact, that the majority of the children were very young.

A table is given showing the results of twenty-three lithotomy operations in children ranging from seven and a half to sixteen years of age, in whom the disease had existed for periods ranging from three months to three years. The largest stone crushed weighed one ounce and a half, and the smallest five grains. The author then relates in detail a number of cases.

The points in the operation which were particularly striking are :

1. That the capacity of the urethra in patients of the same age, varies much more in children than in adults.

2. When the urethra is capacious, litholapaxy may be performed with facility and safety, but the operation is necessarily, a much more delicate one than in the adult.

3. In children the operation is, for the same size of stone, a much more tedious one than in the adult, owing to the small size of the instrument used.

4. There is more danger of a fragment of stone being left behind than in the adult, and careful search must be made before the instrument is withdrawn.

5. In children, after the meatus has been cut, the first two inches of the urethra is, as a rule, the narrowest and most difficult part through which to pass the lithotrite ; whereas, in adults, the difficulty lies generally at the triangular ligament.

6. Re-introduction of instruments is difficult owing to congestion near the meatus.

7. Owing to the curvature of the lithotrite, etc., more difficulty is experienced in its introduction than in passing a sound or cannula.

8. The meatus almost invariably requires to be slightly slit. The incision should be on the floor.

9. Force should never be used in passing the instrument.

The author says further : "I have no cause, certainly, in my own practice, to abandon lithotomy in children for litholapaxy, having now performed 165 lithotomies in children, or lads below sixteen years, without a death." However, he does not hesitate to pronounce litholapaxy a safe and justifiable operation in children in suitable cases. Sixty-one cases in adults were successfully treated by litholapaxy. The average age was forty-four years; the average weight of the calculi, 197 grains. Three of the cases were complicated with stricture, and several with enlarged prostate. Three stones weighed, each, two ounces and upwards. Four minute calculi, which the sound failed to detect, were brought to light by the aid of the aspirator (a method of diagnosis which the author has brought to the notice of the profession).

Attention is called to the great beauty and utility of the handle and locking action of Bigelow's lithotrite, but the construction of the blades is considered inferior to those of the latest patterns of Thompson and Weiss. He regards it as a defect in Bigelow's lithotrite that the female blade is not fenestrated, and has abandoned all but fully fenestrated lithotrites in his practice.

One case was operated upon by suprapubic cystotomy. A lad of sixteen had had symptoms of stone for three or four years and was much reduced. The sound struck a stone at the neck of the bladder, but would not pass. By the rectum the stone was estimated to weigh about two and a half ounces. The patient was a hunchback, with narrow, deformed pelvis, hence, this operation was chosen. Petersen's india rubber bag was introduced into the rectum with ease, and dilated with ten or twelve ounces of water. The bladder was then distended by the injection of six ounces of boracic acid solution, and a soft elastic tubing tied around the root of the penis. The hypogastrium now showed the outline of the distended bladder. An incision three inches long was made in the median line from the pubic bones upward, and the bladder reached by careful dissection. The fundus was transfixed by a sharp tenaculum, and an opening one inch long made by its side in a vertical direction. The opening was then enlarged by tearing in a vertical direction with the fingers. The stone was removed with forceps. A catheter was tied in through the urethra, a drainage tube inserted into the wound, the upper part of the abdominal wound was brought together by a deep suture and a loose corrosive sublimate lint dressing applied. The patient made a good recovery. Regarding the choice of operation, the author refers to Mr. Cadge's lectures, delivered at the Royal College of Surgeons of England, June, 1886.

### ONE YEAR'S STATISTICS OF LITHOTOMY.

In connection with this series of cases treated by litholapaxy, it will be of interest to review the statistics of a year of lithotomy operations performed in the Hyderabad Civil Hospital, Sind, in India.

Surgeon-Major Keelan reports in the *British Medical Journal*, of October 15, 1887, a series of 188 cases of stone operated upon by lithotomy from

June 1886 to June 1887. By the table it is seen that forty-five cases were in children from the age of one to five years and were all successful, in fact there were no deaths among 105 persons operated upon under the age of twenty-five years. From the age of twenty-six to seventy there were eighty-three cases and eight deaths. It is shown also that stone is here more prevalent, in children from the age of one to ten years, and in adults from thirty to fifty years. If the patient has suffered long the diagnosis of a large stone is ventured. One of the stones removed weighed fourteen ounces. It was broken into forty fragments which were all readily removed. This stone cemented together forms the centrepiece of a collection of over 1,000 stones in the author's possession, all removed by literal lithotomy, excepting the very large ones which required the bilateral operation, for which latter the result speaks well. Lithotritry in this hospital is only undertaken when the stone is small and soft. He thinks the fragments of a large and hard stone are next to impossible to remove at one sitting which is imperative. The natives can hardly be persuaded to undergo any operation for stone but that of lithotomy. No difficulty has ever been experienced by the author in removing stones of under five and a half ounces by the lateral operation. Over six ounce stones can be felt through the abdominal walls, and the fourteen ounce soft stone formed a tumor like a contracted uterus.

In removing a large-sized stone one of the most important points is to seize it so as to bring it through the wound in its long diameter. This may be done with the aid of the finger, working it around until the desirable position is obtained. Traction must be made in the direction of the lower outlet of the pelvis. Now this direction with the patient in the lithotomy position is upwards and forwards, so that the operator must stand upon a chair so as to get well above the breech. The parts should be cut and not torn, and the stone not removed roughly or with great force. The tuber ischii must be avoided as the pudic artery runs under cover of it. The other arteries are small and must be severed in removing a large stone through the perineum. In performing lithotomy on children under five years of age, it is regarded as dangerous to pass the finger into the bladder. A grooved director is introduced instead along the groove of the staff which is then withdrawn. A small forceps is now introduced, following the groove of the director and the stone seized. Primary and secondary hemorrhage, regarded with so much apprehension in many quarters, appears in this hospital to be of rare occurrence. Only four of the 188 cases gave any trouble in this way, and the bleeding was always arrested by pressing the lips of the wound together, and applying a pad with pressure made by both hands of an attendant. It was never necessary to tie an artery. The natives of the province attribute the great prevalence of stone to the muddy water of the Indus which they invariably drink.

The nucleus in at least seven out of every ten cases which the author examined, was found to consist of oxalate of lime, and it is known that the water contains carbonate of lime. Religious customs prevent these people from passing urine in other than a sitting position, and it is probable that the bladder cannot completely empty itself.

The author's object in this paper has been to show the slight danger of lateral lithotomy, and the fallacy of supposing that lithotritry or the suprapubic operation will ever supersede it. Still, it is necessary to work without prejudice, weighing each operation carefully.

### WHAT IS STONE IN THE BLADDER ?

IN the same journal of February 18, 1888, Sir Henry Thompson in commenting upon Freyer's paper asks : "What is a stone in the bladder ?" and thinks the term is sometimes loosely employed. He suggests that "any calculus which can be by any means removed entire through the urethra including one impacted therein, and removed thence by the knife, cannot be admitted to rank as a vesical stone, nor can such an operation be regarded as one for stone in the bladder." He finds it remarkable that in the hundred tabulated cases, there were no less than a dozen in which the "stone" did not exceed a dozen grains in weight, and what is still more remarkable, is that a tiny concretion weighing only two grains, is twice reported as "a stone" in the adult bladder, as are also two of three grains each, besides others of four and five grains. The total weight of eight stones in adult cases, was only thirty-seven grains, an average of about four grains each. Such tiny products are easily removed by washing out the bladder, or escape spontaneously. Thompson says that in his cabinet of calculi numbering about 950, removed by operation, not one weighs less than twenty grains, and had he reported cases from this weight down to 5 and 6 grains, the number would be 1,100. He thinks it very desirable to adopt a uniform method in the use of terms, and not to regard "gravel" as "stone." Commenting editorially on stone and gravel, the *British Medical Journal* says that the short but pregnant paper of Sir Henry Thompson raises the question of nomenclature, which has a real surgical interest, and especially for statistical purposes, some sort of agreement should be generally adopted as to the size of calculous particles, which should be designated by the name of "stone."

### CONTUSION OF THE PERINEUM.

A PATIENT in the service of Guyon, at the Necker Hospital, had received a slight injury to the perineum by falling from a horse upon the edge of a cart. This was followed by the flow of a slight amount of blood from the urethra, and retention of urine during the whole day, but there was no swelling in the perineum. This has an important bearing on the case, for in severe cases hæmatoma forms rapidly in the perineum, and there is usually abundant urethral hemorrhage and persistent retention. In this case tunefaction of the perineum came on subsequently, and reached the size of an English walnut by the sixth day, when fever was also present. The tumor was incised, urine escaped, but little blood, and the fever disappeared. An instrument could not be passed into the bladder through the urethra, but found exit through the wound. Urine passed through the perineal wound for ten days, and then normally through the urethra. The wound was healthy, which showed that it is not the contact of urine which is dangerous, but its penetration into the tissues. There is always stricture following these cases, and dilatation must be begun in eight days. In all severe cases the perineal tumor must be incised at once, and we must be ready to do in those which appear less serious. An attempt may be made to introduce a sound à demeure. The reconstruction of the urethra is thus facilitated and septic matters are not retained. —*Journal de Méd et de Chirg.*, February, 1888.

### CALCULUS OF THE URETHRA.

PROFESSOR GUYON showed a patient from whose urethra he had extracted a calculus, which had been in the canal for seven months without causing

any retention of urine. Even where there is stricture, the presence of a urethral calculus, is almost never the cause of retention. In one case in his service the stone had been in the urethra for four years, without causing any accident.

To extract the stone the exact location must first be determined. The situation is usually in the bulbar region. It usually becomes inserted in folds of the mucous membrane, and is not easily expelled. Another favorite site is within the fossa navicularis, and here it occasionally causes retention, but its extraction is easy. To fix the point of arrest, an intra and extra urethral exploration is necessary.

The latter demonstrates a fixed pain, in a well defined point, and this symptom is so constant that whenever pressure in the course of the urethra produces a decided fixed and localized pain, we can almost surely conclude that gravel is present. Intra-urethral exploration is usually faultily made with a metallic instrument. A flexible instrument is much better, which will adapt itself to the curves of the canal, such as the exploring olivary bougie à boule, with which at the same time a stricture can be diagnosed. As regards extraction a bougie should be passed and left for a day or two in the canal, this results in preparing a passage way for the gravel, and may even provoke its expulsion. After this preliminary procedure we must try to seize the stone with a duck bill forceps, while the urethra is so held, that the mucous membrane presents as few folds as possible.—*Journal de Med.*, February, 1888.

#### REMARKS ON ECZEMA AND ITS DIETETIC TREATMENT.

Dr. SCHWENINGER places great confidence in regimen in the prevention and treatment of eczemas and other dermatoses. He insists particularly that good general nutrition is not so requisite as a rational regimen specially adapted to the individual. What agrees with one person may have the most disagreeable consequences in another. There should be no routine dietetic formulas. The author owes his success to his having kept strictly to individualization. In persons who suffer from obesity, with or without disturbances of the circulation, atheromatous changes, hemorrhoids, or degeneration of the heart, eczema is found to exist, sometimes limited to isolated portions of the body, and sometimes generalized. These eczemas the author did not treat locally, but sought rather to regulate the manner of living for each individual, according to his occupation, his age and the climate in which he lives, each patient being treated according to his idiosyncrasy. First of all, a simple regimen must be imperative. Instead of allowing an eczema patient to continue taking liquids (coffee, milk, cacao, tea, etc.), solids are ordered (meat, fish, eggs), and the results obtained are often surprising. In other cases a considerable action is obtained in separating the liquids from the solids. Likewise in a goodly number of cases there is a real advantage in ordering very little food at the time, but taken very often. Change in the hour of meals is also at times of much importance. At times a patient can take in the morning or at noon nourishment which would not be tolerated at night.

In chronic eczemas the quantity of liquid has often a marked influence, and excellent results can be obtained by giving frequent small doses, amounting in the aggregate to four quarts a day. A better cleansing of the body is

obtained by the introduction of small quantities of liquid frequently repeated.

Regulation of the bowels is of vast importance. Not so much by medicine as by preserves, fresh fruits, lemon juice, pumpernickel, bran bread with or without butter and honey, milk with the addition of sugar of milk or other substances.

Fat men have a smooth, turgescient skin, and a tendency to hyperidrosis and are predisposed to eczemas. The perspiration has a constant irritant action.

The eczema disappears as soon as the polysarcia has been removed, and does not return unless the fat accumulates again in excess because of bad hygiene, etc.

In concluding, the author recalls the fact that in salting dishes to a greater extent, eczemas, as well as other troubles of nutrition, tend often to disappear.—*Charité Annalen, Journal de Médecine*, January, 1888.

### IMPORTANCE OF ANTISEPSIS IN DERMATOLOGY.

ALL kinds of microbes exist upon the surface of the body, and specific and infectious ones may at any time be among them, ready to effect an entrance when opportunity offers. Frequent baths and washing with phenic, or boric acid; thymol or sublimate solutions, and the occlusion of erosions by medicated collodion are precautions indispensable in certain occupations. Boric acid in 3 or 4 per cent. solution, or thymic acid 1 gram, alcohol (90%) 4 grams and distilled water 995 grams, will be found useful.

### PITYRIASIS VERSICOLOR.

THE microsporon furfur can be destroyed by Besnier's lotion: bichloride of mercury 25 centigrams, distilled water 125 grams, after rubbing the skin well with pumice-stone soap.

Hardy's formula: sublimed sulphur 9 grams, animal fat 80 grams, can be applied in the intervals.

### IMPETIGO.

TILBURY FOX in 1864, first showed that impetigo was contagious. Simon has always taught it to be communicable. Chaumier is not inclined to make a distinction between impetigo contagiosa and impetiginous eczema, so frequent behind the ears of children. Impetigo granulata appears to him to be of the same order. Impetigo panaris, furnucles, etc., are cutaneous lesions, all probably caused by micrococci of suppuration. Gaucher at the children's hospital first applies a potato starch poultice, cold and sprinkled with boric acid solution, until the crusts fall. The surface is then covered with the following:

R. Glycerole of starch..... 30 grams,  
Boric acid..... 3 grams.

Besnier's and Vidal's treatment have also antiseptics as a base. Vidal causes the crusts to fall with potato poultices, then applies baryta water or a dilute camphor solution. Each impetigo pustule is covered with red plaster containing minium and cinnabar, and changed each day.

Besnier first washes with a 1 to 50 boric acid solution, and covers the part with several layers of gauze wet with the same.



Finally the pustules are covered with an adhesive plaster as follows:

R	Vigo ointment.....	5 grams,
	Boric acid.....	1 gram,
	Vaseline.....	30 grams.

Spread upon fine linen.

### ECTHYMA.

THE lesions of simple, non-specific ecthyma certainly contain microbes. Vidal demonstrated in 1872 that the pustules of ecthyma of typhoid fever, as well as of the simple variety, were auto-innuculable. Lotions with boric acid and corrosive sublimate are the best after the crusts have been removed. Then each pustule may be covered with vigo plaster or Vidal's red plaster, which consists of

Emplast	Diachyli.....	27. grams
	Minium.....	2.50 "
	Cinnabar.....	1.50 "

### BROMIDROSIS.

FETID sweat is, in certain cases, due to the presence of microbes analogous to those of putrefaction, and can be readily found in the sweat of the interdigital spaces. Antiseptics here give the best result. Lotions of boric acid and thymol applied hot; powers of salicylate of bismuth and benzoic acid often succeed.

In the German army they apply with success :

R	Acid salicylic.....	3 grams.
	Amyli.....	20 "
	Talci pulv.....	87 "

Tannin may also be used. Legoux advises, after washing the feet morning and night for two days, in an infusion of walnut leaves, to apply twice daily with a brush :

R	Sig Ferri Perchloridi.....	30 grams.
	Glycerine.....	10 "
	Essence of Bergamot.....	20 drops.

In diabetics, as is well known, inflammations frequently occur about the meatus and glans penis. According to Simon, spores and tubes of mycelium are found in the neoplastic tissues of these patients. He calls the condition balano-postho-mycosis. The diabetic urine constitutes a culture medium for the parasite. The conclusion is that antisepsis of the skin should be particularly rigorous in patients with diathesis and especially in diabetics.—*Le Concours Medical*, Feb. 4, 1888.

### THE GONOCOCCUS IN LEGAL MEDICINE.

AUBERT writes in the *Lyon Medical*, of February 12, 1888, his views regarding the value of the Gonococcus in medico-legal questions. He says the knowledge of the microbe has penetrated to the bar, and the lawyer asks in cases of rape, etc. : "Have the gonococci been looked for?" Rules for collecting and examining the pus are given, but are the same, as will be found in an article by Dr. Allen, published in the March number of this JOURNAL (1887), in which also attention is called to the importance of these micro-organisms in medico-legal practice.

Once dried in a thin layer on a glass slide, the pus can be colored and examined weeks or months afterward if desirable or at once. The cocci are only considered characteristic when occupying the protoplasm of the pus

cells between the nuclei. They are rarely found upon the epithelial cell. The author regards Roux's method of proving the gonococci as capable of real service in doubtful cases. The microbes may be found over the whole ano-genital region, but the urethra is the essential region of their reproduction.

So far in the pus stains upon linen he has been unable to obtain intact globules of pus, or groups of cocci. He refers to two cases of accidental non-veneral infection in two young girls, and of multiple contagion from a water-closet in Florence, recorded in an Italian journal. Such cases must be taken note of by the physician who testifies in court.

The following conclusions are drawn :

1. The gonococcus should be considered characteristic of blenorragic pus, and it should be looked for when it is necessary to determine absolutely the existence of gonorrhoea.

2. Only groups of microbes in the protoplasm of the pus cells around the nuclei should be regarded as characteristic.

3. Examination can only be made to advantage of the pus collected with this intention from secreting surfaces and immediately spread and dried.

4. We cannot say at present that the cocci found upon soiled linen are or are not gonococci.

5. We cannot place confidence in cultures made from linen upon which pus has been dried, for a longer or shorter time, until control experiments have been made by other observers.

6. In young girls especially, blenorragia can result from accidental contagion.

## Book Review.

LEHRBUCH DER HAUT UND GESCHLECHTSKRANKHEITEN FÜR STUDIRENDE UND ARZTE. Von Dr. Edmund Lesser, Privatdocent in der Universität, Leipzig. Erstes Theil-Hautkrankheiten, mit 24 Abbildungen in Texte, und 6 Tafeln. Third improved and enlarged edition. Leipzig : F. C. W. Vogel. 1887.

THE call for a third edition of a work within two years after the issue of the first, must be accepted as practical proof of its value, and the high estimation in which it is held by the profession.

In noticing the first edition of this work we took occasion to commend certain features as most admirable. The description of the various diseases were characterized as "concise, accurate, and excellent." At the same time we pointed out certain defects which detracted from its value as a useful and instructive treatise. These deficiencies were especially manifest in the omission, or the very brief consideration given to new agents and methods of treatment. We are glad to observe that the present edition leaves little to be criticised in this direction. The book has been much enlarged and improved, and the therapeutical part has been brought up to the latest advances made in this department. The author exhibits a judicious conservatism in not recommending new agents, whose therapeutical worth has not been demonstrated by the test of sufficient clinical experience. The photographic illustrations of certain diseases introduced in this edition adds materially to the appearance and value of the work.





DR. MCGUIRE'S CASE OF IODIDE OF AMMONIUM ERUPTION.

JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

MAY, 1888.

No. 5

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**Original Communications.**

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**IODIDE OF AMMONIUM ERUPTION.**

BY

J. CLARK McGUIRE, A.M., M.D.

Clinical Lecturer on Dermatology, Hospital School of Medicine, Louisville, Ky.

**T**HE fact that the ingestion of certain medicines may produce eruptions of the skin has been long known to physicians, but only recently has the attention of the general practitioner been especially called to their occurrence; there is hardly a drug known that is not capable of producing an irritation of the skin by its internal administration. The subject has recently been most forcibly called to the notice of the profession by the exhaustive treatise on "Drug Eruptions," by Prof. Prince A. Morrow. He says "comparatively few cases of bullous eruptions caused by the ingestion of iodide of potash, are found recorded in the literature of drug eruptions, and it may therefore be classed among the rarer manifestations of the drug."

Though iodide of ammonia is more liable to cause irritation of the skin than any other preparation of iodine, I have not seen a case of bullous eruption reported from its ingestion. Therefore, the report of the following case may be of particular interest:

February 22, 1888, I was called in consultation by Dr Hunt

Stucky, of this city, who gave me the following history of the case: "Mr. R——, æt. 51, was employed in storing lumber from a sweat box. On the 1st of October, 1887, he left for his home, some distance away, while his clothing was saturated with perspiration. Soon after reaching his home he had a severe chill, followed by fever. The following morning he complained of a pain in his chest and difficulty in breathing. Diagnosis: Broncho-pneumonia." On January 27, 1888, Dr. Stucky first saw the case. He then found "the affected side somewhat contracted; respiration accelerated; expectoration muco-purulent; complete absence of true vesicular breathing; pulse 120; temperature 102°. Ordered quinine, whisky and the following tonic:

R Hydrarg Bichloridi.....	gr. i.
Ammonia iodidi.....	3 ss.
Sarsaparilla.....	3 ii.
Elix Malt. aromat ad.....	3 iii.
Dose, two teaspoonsful after meals.	

After taking several doses—about twenty grains of iodide of ammonia—a vesicular eruption appeared on the scalp, face and shoulders. Mixture discontinued. In a few days the vesicles disappeared. About two weeks later the tonic was again given in one teaspoonful dose after meals. After four doses—about five grains of the iodide—had been taken, the eruption reappeared and attained its maximum development in ten days after the drug was discontinued."

February 22d I was called in consultation and found an eruption, consisting of vesicles and bullæ, situated on the scalp, face, trunk, thighs and legs. The lesions on the scalp and face varied in size from a split pea to a pigeon's egg—those that had not broken were markedly umbilicated, of steel color and surrounded with a slight areola. On the left side of the scalp several bullæ had coalesced, broken down and were discharging bloody serum. From the groin to the ankle various sized bullæ were situated. On the outer side of left thigh, several had coalesced and were covered with bloody crusts. The umbilication and indurated edges are very well shown in the photograph taken at this time. On the calves many bullæ had broken, presenting a raw-beef looking surface, and elevated edges; both feet and ankles very much swollen, and pitted on pressure. The lesions on the back presented very much the same appearance as those described elsewhere. The skin was neither infiltrated nor reddened between the lesions, except on the face and scalp. There was

no eruption on the hands, feet or abdomen; mucous membrane unaffected. No subjective sensations.

Patient was listless, drowsy and would fall off to sleep almost instantly after being awakened. Ordered whisky, cod-liver oil, lesions to be opened and dressed with carbolized vaseline. Four days later, that is, on February 26th, some new lesions had appeared. Many bullæ had become confluent, especially about the scalp, covered with dark crusts. Many were discharging a thicker sanguineous pus than when last seen. Examination of urine found acid in reaction—sp. gr. 1022, with only a trace of albumen. The lesions on the back, thighs and legs had increased considerably in size. Ulcerating surfaces, situated, apparently, a little below the surface of the surrounding skin, from the fact that their periphery was elevated and hardened, odor very offensive, no new lesions appeared after this—ten days after the medicine was discontinued—the raw-beef looking surfaces gradually healing, especially on face and scalp.

March 7th. Lesions on the face on a level with the surrounding skin, very much improved in appearance. Ulcers on the legs bathed in thick pus; extremely fetid odor. Patient failing; pulse cannot be counted. Respiration thirty-four. Died on the night of March 7th, from apncea.

The two photographs of the face and scalp are particularly interesting, as they show how greatly the lesions had increased in size in four days from February 22d to February 26th, the white spots observed in the last picture were caused by the dressing of vaseline reflecting the light particularly at these points. The photograph of the leg shows the lesions plainer as the proof was from a clearer negative. Though it has been suggested that the eruption in this case might be a manifestation of syphilis, there is no doubt in my mind it was directly due to the iodide of ammonia, for the following reasons, the appearance of the eruption within four days after taking the drug, that it faded away in a few days after its discontinuance, its re-appearance after 5 grains more had been taken, and its gradual fading away the second time after reaching its maximum development, on the tenth day, its resemblance to other bullous eruptions reported as due to the ingestion of preparations of iodine, and from the fact that there was no other known cause for the eruption.

The patient and his wife positively denied that he had ever had an eruption of any kind before; there was absolutely no

history of syphilis, the only disease it at all resembled in appearance. But it could not be due to this disease, since a vesicular eruption is a most uncommon manifestation of syphilis ; when it does occur the vesicles are not so extensive in their distribution, they are not so markedly umbilicated, there are no dark bloody crusts from these lesions, and other lesions, such as papules, are usually present. Then it is to be remembered that vesicles appeared in this case, quickly increased in size till they became bullæ the size of a pigeon's egg, the contents at first bloody serum soon changed to sanguineous pus, drying up, and beginning to fade away, all within ten days ; this is not the history of an eruption due to syphilis.

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REMARKS ON THE VESICO-URETHRAL ERETHISM PECULIAR  
TO LOCOMOTIVE ENGINEERS.<sup>1</sup>

BY

JOHN BLAKE WHITE, M.D.

Physician to Charity Hospital. Consulting Physician to House of Refuge.

**I**N due order of rotation of privileges, it becomes mine, to present to our select body, this evening, a topic for your entertainment and discussion.

The subject I propose to submit to you has long afforded me interesting study and is comprised, I feel assured, within quite an original field of observation. Since this matter has challenged my attention I have diligently searched for previous literature, but in vain, and I find that I am in this important lookout, a solitary sentinel.

The novelty, however, of the subject, will serve to render it acceptable to you even though I may fail to surround my theme with the ordinary concomitant and attractive testimony of other observers.

The influence of occupation as an etiological factor in the causation of disease, is fully recognized by all. So important an element is it in the many conditions which are constantly warring against the human system, that a diagnosis can often be immediately made when the sufferer, who applies to us, announces his vocation. Hence, many of the diseases, to which flesh is heir, are the result of particular occupations, directly, and the importance of paying more than passing attention to each individual patient's employment, cannot be too strongly

<sup>1</sup> Read before the Yorkville Medical Society, February 23, 1888.



urged, for purposes of diagnosis and treatment. In certain affections it is possible to obviate, in a measure, the obnoxious effects of occupation while the patient continues to be engaged in the same way, but in others an immediate and permanent change of vocation must be insisted on, if beneficial effects from treatment are to be looked for.

It is my desire this evening to call your attention to a condition of irritability of the urethra accompanied with impaired power in the bladder to which locomotive engineers are especially subject. This is a condition which, with few exceptions, uniformly affects this class, and though it is exceedingly annoying, is nevertheless quite amenable to treatment, but if neglected may lead to obstinate if not serious organic changes in the urethra, bladder and adjacent structures.

The erethism, with impaired power about the bladder referred to, is occasioned by the series of vibrations, imparted by the action of the engine in motion, intensified by the character of the seat used by the engineers. Ordinarily the engineer sits astride of a narrow seat, which presses solely on the perineum. Such a seat gives rise most promptly to the symptoms complained of, as it transmits directly to the perineal portion of the urethra, as well as to the neck of the bladder, a constant series of sudden shocks or succussions, soon establishing an erethistic state of the sphincter, vesical accelerator and ejaculator urinæ muscles, resulting in a frequent desire to micturate. In many cases this symptom is so very urgent and persistent that a painful incontinence of urine ensues.

Many of the symptoms presented by this class of cases are similar to those of organic stricture, except that there is seldom a sensitiveness induced by instrumental measures, for purposes of diagnosis, as it is the case in the latter condition. A spasmodic resistance to the introduction of a sound is sometimes observed, but when this symptom is present, a stricture of large calibre in the penile urethra may be expected as a complication; and located without doubt, if a careful investigation is made with bulbous sounds. It is difficult to establish a correct diagnosis in these cases, except by the method of exclusion, because urethral erethism without central lesion is a constant symptom of organic stricture, which sometimes co-exists with the type of urethral irritability under consideration.

It is important to differentiate between these conditions of urethral irritability, because the treatment would be necessarily different. When stricture is present, dilatation often relieves the

irritation, in a measure, while it is not an advisable procedure in the uncomplicated type of urethral erethism which we have been describing, and seldom proves advantageous in the form which is due to central lesion. When due to the latter cause, complete mental and physical rest should be enjoined, but in the engineer's form of erethismus, relief can be obtained without necessarily causing the patients to cease work, provided attention be given to diminishing the vibratory shocks sustained by the perineo-urethral cushion. As the cause is mechanical, this can be effected by providing a seat with a soft, elastic cushion, supported by easy springs, arranged so that the weight of the body will be mainly supported by the gluteal muscles, the seat itself thus being made to yield to the jarring and vibration of the iron horse.

Very little medication, as a rule, is required, but some decided benefit, when the symptoms are especially severe, has been realized from suppositories of belladonna and strychnia. I have found the internal administration of the fluid extract of pichi, belladonna, extract of cannabis and strychnia, combined with the warm sitz bath, medicated with kreuznack salt, effectual in some cases. The bath particularly lessens irritability about the pelvic viscera, and when used adds undoubted tone to the urinary organs.

The usual symptoms associated with this form of urethral irritability are all aggravated by the presence of stricture, either of large or small calibre, and whether complicated by stricture or not, the degree of vesical tenesmus is sometimes so severe as to excite the suspicion of the presence of a vesical calculus.

When stricture exists as a complication, gradual dilatation should not be practiced if much sensitiveness of the urethra manifests itself, until the latter condition has been to some extent, at least, overcome by appropriate treatment. Some degree of incontinence of urine will continue as long as a stricture is permitted to remain, but relief, without operative procedure, may follow the simple plan of treatment which has been suggested.

I have not found it necessary nor advisable to put off an operation for the relief of stricture simply because some urethral irritability remains, but, on the contrary, I would advise operation in most cases, believing that an earlier recovery would be the result. After operation, the same precautions concerning the character of the seat should be strictly carried out or a relapse would certainly follow.

A better example of a typical case cannot be afforded than to recite a brief clinical record of one which was recently referred to me by a medical friend, supposing that the symptoms complained of were due to stricture.

J. P—, æt 35, married, an engineer on one of the elevated railroads.

Twelve or thirteen years ago he had an attack of gonorrhœa, but since then he has been perfectly well. About two years ago he began to be annoyed by a frequent desire to urinate, which was always accomplished with some difficulty and invariably followed by severe pain extending from the back, around both sides along the track of the ureters to the bladder, over which latter organ a decided sense of weight was felt. He has never had retention of urine and at the time he consulted me there were no evidences of cystitis. He was in the habit of taking some medicine prescribed by his family physician which he thought relieved him at times. The constant desire to pass water has continued, followed by less pain, though he frequently experiences a burning sensation at the neck of the bladder. An incontinence of urine troubles him especially if he is obliged to hold his water after he feels an urgent desire to empty the bladder.

During the night, while in the recumbent position these symptoms are abated. While at work he feels the jarring sensation imparted by the engine at the neck of the bladder, which is soon followed by a cogent desire to micturate. If he fails to respond to this he realizes that he has lost control of the sphincter, and urine escapes incontinently.

The disagreeable as well as serious consequences which might follow such a state of things, if allowed to continue unrelieved, will be readily appreciated.

The penis measured  $3\frac{1}{4}$  inches in circumference. A careful exploration of the penile urethra was instituted with Otis's urethrometer and bulbous sounds. The former instrument was inserted as far as the membranous junction of the urethra and the index raised to 33 F. when it was slowly withdrawn as far as the meatus without hindrance, but at this point it emerged at 30 F. This very nearly proved to be a urethra of the highest type according to Dr. Otis's estimate of the relation which the circumference of the penis bears to the urethral capacity in a healthy condition; the facility with which a 32 F. sound was introduced into the bladder, excluded the existence of any lesion beyond the bulbous portion of the urethra, to account for the

symptoms complained of. Some sensitiveness was felt as the instrument reached the neck of the bladder. As the sound was withdrawn it was grasped only at the meatus which was dilated from 30 to 32, French scale, as the latter instrument was inserted. A 30 F. bulbous sound would be passed up and down the urethra without catching at any point. The urine was examined and proved normal as to color, reaction, component elements and specific gravity.

Nothing could be found to account for the irritability described, except the mechanical irritation superinduced by the constant vibration of the engine, transmitted to the urethra and neck of the bladder from the narrow hard seat which this patient used for hours every day.

The treatment, which has been detailed above, was that which this patient received. He was directed, futhermore, to provide a softer cushion for the seat he used, and to sit sideways rather than astride of the seat, which is the most frequently adopted plan. I have since learned from his family physician that the treatment and precautions advised have afforded him effectual relief. Such has been my experience with other cases.

Strictures of large calibre, I find, are frequent complications, and unless these receive due attention the symptoms are decidedly aggravated.

Enlarged prostate is sometimes a complication, and, I am inclined to believe, is not infrequently occasioned by the continual irritation set up in the urethra and bladder by causes which have been already mentioned.

When this condition is present the warm sitz bath will prove a valuable resource, and the patient should, at least once daily, void his urine while in the bath. Internally, benefit will follow the use of pichi, belladonna and strychnia.

As a result of this continued neglected erethism, a troublesome cystitis may develop. To relieve this condition, the warm bath, the administration of urinary sedatives and the washing out of the bladder are measures clearly indicated. If there is much recent vesical irritation, a one per cent. solution of cocaine with borax and glycerine will grive prompt relief. Diluents are valuable adjuvants to the treatment of these cases, and the purest natural spring waters are the best, such as the Underwood, ærated or non-ærated, Poland, Buffalo, Lithia, Clysmic and others.

CIRCUMSCRIBED ATROPHY OF THE SKIN, POSSIBLY OF  
HEREDITARY ORIGIN.

BY

T. CURTIS SMITH, M.D.

WITHOUT attempting to enter into the study of this disease, or its true pathology, I propose to relate the history of the following case and let it stand for what it may be worth.

Mr. S.—. æt 28, farmer, of steady, good habits, single, of dark complexion, has a very good family history, as there is no rheumatism, gout, scrofula phthisis, blood or nervous disease known in the family. He came to me in the summer to show me some white maculæ located on his hands and face, which were annoying him very much. He stated that they had been in existence two years or more, and were most noticeable in warm weather, and when the hands were cold they were much less perceptible. He further stated that his father had been troubled with white spots on his hands for a good many years before his death, which had but recently occurred. The father was the subject of occasional severe attacks of colic, and died of intestinal obstruction.

Mr. S.—, the patient, was a large, well formed, stout, healthy farmer, had never been afflicted with any form of cutaneous disease except the one under consideration, and had not in this instance noticed any abnormal condition of sensation in the skin, nor had there been any known injury, local or general, to cause the maculæ, that he could recall. The spots were located on the dorsal surfaces of the hands, fingers, and wrist and on the palmar surface, also, of the wrists, and on the face spots the size of a nickle on the forehead just above the right brow, and at the inner and outer canthus of the left eye, outer canthus of the right eye, and near the left angle of the mouth. The maculæ were of rounded or oval contour, from the size of a small split pea to that of a nickle, and about the color of pure lard, possibly a shade darker. There were no patches at other points than those named. The maculæ were quite smooth, without hairs, the pores were visible in nearly all of them; I could not positively detect any thinning of the skin in the macular patches by the touch, but on pinching them up thought I could observe a distinct difference in its thickness compared with the healthy skin. The margin of each was distinct and there was no shading off into the normal color. To the eye these spots seemed de-

pressed, but I could not observe them to be so by passing the finger over them, nor could I detect any thinning of the subcutaneous fascia. The affected skin was less rough than the normal. The maculæ above the eyes were quite distinct. Those around the eyes gave the appearance of the face having been powdered with flour and rubbed off again. The spot at the angle of the mouth was red and erythematous when I first noticed it, but later it assumed the same appearance as the others. No distinct abnormal condition of sensation was observed in any of the spots. When the patient's hands were quite cold the maculæ were less visible than while warm, and were much less distinct in winter than in spring and summer.

The treatment was more successful than I expected, this consisted of the internal use of arsenic, and sulphide of calcium, the latter being used for only a short time, the former for a long period. The local treatment consisted at first of strong mercurial ointment, later the local use of electricity was resorted to, by means of small batteries made of zinc and copper plates with a layer of cloth between, wet with acid solution, these were applied at bed-time and worn through the night. Also two or three times a week, at my office a very strong constant current was applied for 20 to 30 minutes. As soon as the electricity was fairly begun improvement was observable, this with the arsenic was continued with some degree of regularity until the following spring. As the maculæ by this time were *very dim* and did not reappear when the warm weather commenced the treatment ceased. The spots have not since become bright but can be seen on close inspection.

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## Society Transactions.

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### THE NEW YORK DERMATOLOGICAL SOCIETY.

#### THE 180TH REGULAR MEETING.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. KLOTZ presented a case of

#### LUPUS ERYTHEMATOSUS OF THE EXTREMITIES.

The full history of the case was reported by Dr. Klotz, as case II. in his article on "Lupus Erythematosus," in the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES No. 65, February, 1888.

In the discussion, DR. MORROW said that he thought that the papillomatous lesions developed upon the posterior portion of the foot, were very sug-

gestive of syphilis. He had seen cases of that disease which were almost accurate reproductions of the present case. Still, the great chronicity of this patient's disease, its being unaffected by specific treatment, and Dr. Klotz's opinion, based upon long and careful observation, would induce him to concur in the diagnosis.

DR. FOX stated that lupus erythematosus on hands and feet was uncommon. He could remember having seen one case on the hand, which was typical in appearance, and one in which the disease was present on the scalp, the hand and the arm. He would not think of syphilis in the case presented to-night by Dr. Klotz, but rather of lupus. The patch on the buttock, he considered as lupus vulgaris; that on the ankle, as lupus verrucosus. Dr. Fox thought that the verrucous form of tuberculosis was quite frequently met with on the hands and feet.

DR. PIFFARD agreed with Dr. Fox's remarks. The case corresponded, in his opinion, to the scrofulide verruqueuse of the French. He saw nothing in the lesions of this patient resembling lupus erythematosus, and he had never seen that disease become verrucous.

DR. ALLEN agreed also with the two preceding speakers. The lesions were not those found in lupus erythematosus, and he thought that the patch on the back of the leg was very like lupus vulgaris.

DR. SHERWELL said that the patches on this patient did not resemble those he had seen in cases suffering from lupus erythematosus of the face. He would also insist upon the fact that a scrofulide was a small cell growth in a scrofulous person.

DR. ELLIOT said that he would consider the case as one of tubercular lupus, but he would differ from Dr. Fox in considering lupus verrucosus and tuberculosis cutis verrucosa as the same. They were both forms of tuberculosis of the skin, it was true, but clinically they differed, inasmuch as the former always developed from a lupus exulcerans, whereas, in the latter there was never any ulceration primarily.

DR. TAYLOR asked by whom that distinction was made.

DR. ELLIOT said that Reihl and Paltanf, who first described tuberculosis cutis verrucosa, had done so in their article on the subject, and their views had been generally accepted. The distinction was emphasized also by the fact that in lupus verrucosus the brownish nodules characteristic of the disease were found to be present, whereas, in the tuberculosis cutis verrucosa, they had never been seen. There were, besides, other points of difference between the two, which, though minor, yet furthered the view that a distinction should be made.

DR. KLOTZ, in summing up, said that he had doubted the diagnosis very much, and would not have made it but for its great similarity with case 1. reported in his article. He did not think it was tuberculosis cutis verrucosa, since there was no suppuration present, but only the papillomatous character described by Reihl and Paltanf. Owing to the great improvement of the case under treatment, he thought it was difficult, however, now to determine the nature of the disease in this patient.

DR. FOX presented a case of

#### ACNEIFORM LUPUS OR LUPOID ACNE.

The patient was first seen two years ago, when there was an eruption upon the crown of the head of eighteen months' standing. It consisted of papulo-pustules tending to form groups. Some of the lesions were umbilicated, and nearly all were excoriated. The diagnosis of acneiform lupus was the only one thought of at that time, although the eruption had been treated for eczema.

About a month ago the patient came to the Skin and Cancer Hospital. The eruption had extended upon the forehead and temples, and numerous small cicatrices were to be seen. The eruption appeared now like a tubercular syphilide, although intense pruritus was still a prominent symptom. As some regarded it as syphilitic in character, he put the patient upon a mixture of biniodide of mercury, and iodide of potash, with no local application whatever. In three days the itching had entirely subsided and the eruption looked better. Within a week a notable improvement had occurred—so great, indeed, as to almost confirm the diagnosis of syphilis.

DR. MORROW, in the discussion, said that he would be more disposed to regard the case as one of lupus acnéique of the French than of syphilis.

DR. KEYES stated that he could not say it was not syphilis, but would not say it was. The absence of history of syphilis would not be conclusive evidence against that disease, still his impressions were against syphilis.

DR. FULLER said that he would have considered it lupoid acne, unless the specific treatment had improved it so greatly.

DR. ALLEN had seen ordinary lupus improve under such treatment, and had also seen cases of syphilis resembling Dr. Fox's case. He would regard it as syphilis.

DR. SHERWELL agreed with Dr. Keyes. He thought the tumor over the eye was a dermoid cyst and not a gumma. He would be inclined to consider the case as one of lupoid acne. He has under treatment a companion case to this one, in a lady, who also presents lesions on various parts of her scalp. The affection being lupoid in character, he would consider it as such in spite of improvement under specific treatment.

DR. KLOTZ did not think that syphilis could produce such changes as were present. He had also had a case of lupoid acne, which had improved under specific treatment, but did not think that that fact alone could decide the question.

DR. JACKSON thought that the case was one of syphilis.

DR. ELLIOT stated that he thought the case to be one of acne varioliformis. He did not think it was syphilis since none of the lesions and not even the cicatrices present, resembled those occurring in syphilis.

DR. FOX in summing up said that he regarded the eruption as a phase of lupus erythematosus. The name acne varioliformis was applied by Bazin to molluscum contagiosum, afterwards to the affection under consideration, which was also later termed acne atrophica or lupoid acne. It was in reality not an acne, and some months ago an account of the itching he had called it acneiform lupus. The affection was often regarded as syphilitic on account of its color and general appearance. In this connection, he would refer to cases of tubercular syphilis of the occiput which were sometimes attended by great tenderness and some itching. In acneiform lupus, Dr. Fox had invariably found the local use of the ammoniated mercury ointment of great value and in many chronic skin diseases having no dependence upon syphilis, the "mixed treatment" was frequently of decided benefit.

DR. MORROW said that he thought the term *lupus erythemato-acnéique* was the best for cases like Dr. Fox's. He did not think that the lesions resembled syphilitic ones in any way. In regard to tubercular syphilides of the occiput, he had found them accompanied by more or less pain when ulcerating, and when the periosteum was involved, the pain was sometimes very great.

DR. FOX presented a case of

#### ATROPHY OF THE NAILS.

The patient was a girl twelve years old. The disease began one year



ago on the little finger of the right hand, involving successively, and in regular order, the fingers of the same hand. A few months afterwards the left hand became affected. The toes showed implication about six months ago. The process began as a yellow streak running down the nail. All those affected are discolored, blackish or brownish, split and striated. Left thumb nail somewhat thickened.

DR. FOX stated that he was convinced that the affection was not the result of an inflammation, nor of a general disease, nor of ringworm, nor of favus. If it was favus there would without doubt be favus on other parts of the body at the same time. He thinks that onychotrophia would characterize the affection perfectly well. He did not think that local treatment would be of any avail, but that general improvement of health might help to cause improvement.

DR. PIFFARD presented the photograph of a case of

#### FAVUS IN A BABY.

The baby's mother had been seen by him, and he found that she had had favus, though not at the time presenting any lesions. Shortly after, she brought the baby to him and he found the distinct well marked favus cup on its scalp. The baby was then six weeks old. Dr. Piffard thought that this was the youngest case of the disease, which had been seen.

The Society then went into Executive Session.

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## Correspondence.

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### DERMATITIS VENENATA.

*To the Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES :*

SIR—As the time will soon arrive when cases of dermatitis, caused by the action of various irritating plants, such as *rhus toxicodendron*, and *rhus venenata*, will be presenting themselves, permit me to offer a plan of treatment that I have found very efficacious in such maladies in this locality. The treatment is purely empirical, I have never been able to explain its action, and, so far as I know, is original. I was led to use it from once hearing a distinguished physician recommend butter-milk in chronic eczema with raw weeping surface, not very unlike in appearance the first stubborn case of dermatitis venenata in which I tried the remedy.

The treatment consists in saturating soft muslin or linen cloths in butter-milk, and applying them in three or four thicknesses, to retain moisture, over the affected part. The cloths should be re-saturated and applied every hour or two, and the applications continued from six to twelve hours. At the end of that time stop the applications, and coat the affected surface with pure vaseline, gently but thoroughly applied so as to cover all the affected surface. Over this may be spread for protection, a strip of muslin coated with vaseline, or better still, a covering of oil silk. The same treatment may be repeated, if necessary, but usually one application is sufficient.

This treatment is not effective in all cases, but I found it to suffice in about three out of four cases presenting themselves. It is not unusual to find

a raw, inflamed, extremely irritable patch of dermatitis transformed by the treatment into a rapidly drying healing surface, free from irritation, and this sometimes within the short space of twenty-four hours. In one severe case, in a lady, brought on by an exposure during a fishing excursion, nearly the whole body was affected, and the difficulty had steadily increased for ten days under domestic treatment, which included olive oil, carbolized lotions, and copperas water. I ordered cloths saturated with butter-milk, to be applied as above, to the hands, wrists, and ankles where the eruption was worst, and butter-milk baths to be taken every three hours, after twelve hours the milk to be discontinued, and vaseline to be thoroughly applied to all parts of the body where any eruption was to be found. At the same time, I gave internally, full doses of quinine and carbonate of iron. The trouble was practically at an end in forty-eight hours.

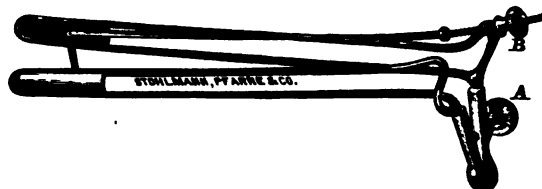
There are a few cases in which this treatment seems to do no good whatever. It never does the slightest harm, however, and is so simple and readily available, that I have no doubt it can be made frequently useful.

J. M. LATTA.

MILLERTON, KANSAS.

#### A New Urethral Speculum.

This cut shows an instrument made for me two years ago by Stohlmann, Pfarre & Co. At times it is serviceable when those of other designs are not. The fault with many instruments intended for this purpose, is the pain caused by tension of the meatus, especially when this part, as is often the



case, is tighter than the parts within. Again the unsupported tips of a speculum converge, giving a funnel-shaped opening, into which it is difficult to secure a satisfactory view. These two annoyances increase proportionately with the spread of the speculum, by reason of the increased resistance, whether at tip or base, being conveyed to the most yielding part of the arms of the speculum, namely, their free extremities; the increased resistance adding at the same time to the pain.

To obviate these difficulties, I have placed a lever, similar to that in my metro-urethrotome, at the distal end of the speculum, its contact with mucous surfaces being prevented by side plates. This lever is controlled by the screws with B., running on a thread and bearing against the head of one pair of lateral rods. The spreading of the proximal part of the speculum is effected as usual, by a screw, A., at the base. By this means the tips and base of the instrument are independently controlled, consequently the arms may be spread so as to be parallel or to converge at either extremity. In this way any part of the urethra, to the depth of four inches (the length of the arms) can be distended at will.

This drawing represents the tips well opened ; the base moderately so.

F. TILDEN BROWN,

40 East Thirty-first Street.

### Iodoform Eruption.

*To the Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES :*

SIR—In the November number of the JOURNAL there is a report of a paper read by Dr. R. W. Taylor, upon the "Toxic Effects of Iodoform." I have recently seen a case of this kind in a patient with pulmonary phthisis for whom I prescribed about eight weeks ago capsules of

R Iodoform..... 1 gr.

Creosote.....'mss.

M. Sig. One after each meal.

The medicine seemed to produce no ill-effect until he had been taking the capsules about six weeks. Then a few purpuric spots appeared on one ankle, and were followed in twelve hours by a uniform sprinkling of the same kind of petechiæ or hemorrhagic spots over the whole foot and leg, and to nearly the same extent upon the other foot. He had this eruption nowhere else. Coincidentally with the purpura he had rheumatoid pains in all the larger joints. I directed him to discontinue the use of the capsules, thinking that the iodoform was the "origo malis," and in a couple of days the hemorrhages were beginning to be absorbed, and no new spots had appeared. In a short time the skin became entirely well and the joint pains had ceased.

I am very sincerely,

C. G. R. JENNINGS.

BENNINGTON, VT.

## Book Review.

ATLAS OF VENEREAL AND SKIN DISEASES. By Prince A. Morrow, A.M., M.D., Clinical Professor of Venereal Diseases, formerly Clinical Lecturer on Dermatology in the University of the City of New York ; Surgeon to Charity Hospital, etc., New York. William Wood & Co., 1888.

THE first three fasciculi of Dr. Morrow's new Atlas of Venereal and Skin Diseases have been received, and will bear out the publisher's promise, to present to the profession a collection of plates both accurate in drawing and with a coloring faithfully representing nature.

The fifteen colored plates contained in these first numbers illustrate the initial lesion of syphilis in its varied forms, both upon the genital organs and upon other portions of the body, chancroid in a great many different situations, forms, and stages of development, both simple and complicated with bubo, phimosis, paraphimosis, etc., and some of the secondary eruptions of syphilis. Especially noticeable is plate viii, which contains illustrations of seven different varieties of extra-genital chancre. Plates xi and xii are taken from Kaposi's recently published atlas, and show, in a very beautiful way, the macular syphilide or roseola.

The drawing and coloring of the actual lesions show much painstaking care, and are for the most part quite true to nature. A few figures of the

plates of the first fasciculus, however, leave something to be desired in the matter of coloring and flesh tints, and the standard of the subsequent numbers is not reached.

The selection of cases for illustration has evidently been made with a view of presenting rather such as are commonly met with in practice than to bring together rarer forms of disease. An exception may possibly here be made for the plate illustrating chancre by vaccination. Since arm-to-arm vaccination has so completely gone out, this unfortunate accident must be a rarity. Still the plate is so beautiful that its presence can scarcely be objected to, and may serve the good purpose of a reminder that the lancet should always be scrupulously clean before each separate vaccination.

The original text, written by the editor, Dr. Prince A. Morrow, presents in a concise and attractive manner our present knowledge of the nature, diagnosis and treatment of the diseases under consideration and which are illustrated by the lithographic plates. Thus is added to the collection of plates a complete and practical treatise on the combined subjects of skin and venereal diseases. The introduction deals with the doctrines of Unity and Duality; then follows in each fasciculus from sixteen to twenty folio pages of carefully prepared text. Especial attention is given to the treatment of the various affections, and the therapeutical portion is brought well up to date.

The work of the lithographers, Messrs. Lindner, Eddy & Clauss, can only be praised.

The presswork is excellent, and the printers have produced an attractive and inviting large, clear, black type impression.

One printer's error is, however, noticed. The description to plate xiii fits plate xiv and vice versa. This mistake would readily be noticed by the reader and corrected by a simple change of numbers. When completed the work will consist of fifteen parts, and together make an imperial folio atlas containing seventy-five full-page plates.

Taken as a whole, the numbers already out indicate that the work is remarkably well gotten up for the price of the subscription, which is \$2 00. Considering the number of plates and the quality of the work, this seems very low when we remember the great expense of such atlases as those of Hebra, Ricord, Alibert, and others.

C. W. A.

**A PRACTICAL TREATISE ON DISEASES OF THE SKIN.** By John V. Shoemaker, A.M., M.D., Professor of Skin and Venereal Diseases in the Medico-Chirurgical College, of Philadelphia; Physician to the Philadelphia Hospital for Diseases of the Skin, etc., etc. With colored and other illustrations. New York: D. Appleton & Co., 1888.

THE present era of dermatology may be characterized as essentially prolific in the bringing forth of books. At no previous period in its history has there been so much productive activity displayed in this direction. Within the past several months, three text-books on diseases of the skin have appeared in English, to say nothing of at least two other works in active course of preparation.

This extraordinary literary fecundity of a comparatively new specialty does not necessarily indicate that the recent advances in our knowledge of skin diseases have been so material as to demand new treatises for its full and complete exposition, but is rather due to the recognition of an increased

interest in dermatology on the part of the general profession and a growing demand for this class of works.

Although scarcely a score of years have elapsed since dermatology began to be cultivated as a distinct specialty in this country, contributions of American dermatologists to its periodical and permanent literature have been numerous and notable. Within a little more than a decade, no fewer than six more or less complete and systematic treatises on dermatology have emanated from American authors, all of which may be considered as creditable, and constituting valuable acquisitions to the literature of the subject.

The book before us—whether the characterization be considered eulogistic or be regarded as a reproach—is the most American of them all, or rather the most distinctively personal, since, while this work does not differ essentially from the others in its general arrangement and description of the diseases, the author's views as to "the relative effects and values of numerous agents tested in his own many years' experience in the treatment of skin diseases," are especially original. In this respect, the book cannot be considered a fair exposition of American dermatological ideas and practice, as many of the author's peculiar therapeutical resources have not been generally adopted by other dermatologists in this country.

Certain features of the work are quite commendable. The classification adopted is a modification of that of Hebra, which though defective in many respects from our present stand-point of pathological histology, possesses the advantages of simplicity and convenience. With all its imperfections it constitutes a much better working basis for the student, than the more elaborate and scientific systems of classifications recently proposed, which although admirable as epitomizing our knowledge of skin diseases, are too complex and cumbersome for practical purposes. The descriptions of the clinical features of the different diseases, their differential diagnosis, etiology and pathology are clear, concise and sufficiently complete; they correspond in the main with those of standard authorities. In this work, due consideration is very properly given to the eruptive fevers. This clinically important class of affections is too often ignored, as beneath dermatological notice, or out of place in a text-book on diseases of the skin.

Another feature of interest and value, is the description of the cutaneous disorders that follow the ingestion, or the external application of medicinal substances. Drug eruptions so often accurately simulate the exanthemata, as well as certain idiopathic affections of the skin, that a knowledge of their objective characters is a matter of great importance in making a differential diagnosis.

The therapeutical part of the book constitutes its distinctive and most note-worthy feature; whether it will prove the most valuable, will depend upon whether the author's somewhat enthusiastic claim of the therapeutic worth of certain agents and modes of treatment, shall be confirmed by a more extended clinical experience. Of one class of agents, which, while not originating with Dr. Shoemaker, have been most prominently brought into notice through his advocacy, viz., the oleates, it may be said that in the hands of others they have, with one or two exceptions, proved disappointing, and it is doubtful whether they will hold a permanent place in dermatological therapeutics.

The only criticism we would pass upon this part of the work, is the absence of a judicious conservatism in recommending remedies which have

not been subjected to a sufficiently practical test. We think that the author has not only allowed his personal predilections in favor of certain remedies to overrate their efficacy, but has permitted his prejudice to depreciate other agents which have a recognized and well established value. As an instance of this, we find that upon what would seem to others quite insufficient grounds, the fatty products of petroleum are entirely tabooed. A cursory examination of the numerous formulæ for ointments, with which the book abounds, shows that in none of them does vaseline enter as an ingredient. Now, according to the experience of other dermatologists, this excipient is recognized as the least irritating, and the most elegant and permanent basis for ointments that has ever been employed.

In the conclusion of his preface, the author adds: "That the whole work has been written from the standpoint of the active general practitioner, and cannot fail to bear that impress." The book certainly possesses many features which will doubtless commend it to the favor of the general practitioner; it abounds in suggestions as to treatment, and, in addition to the multiplicity of formulæ with which the text is copiously supplied, there is an *embarras des richesses* in a formulary embracing sixty pages, which is found appended.

The book is printed in clear type, on good paper, and leaves nothing to be desired in the matter of typographical excellence. The colored illustrations cannot be recommended for their artistic excellence.

**THE HYGIENE OF THE SKIN, OR THE ART OF PREVENTING SKIN DISEASES.**  
By A. Ravogli, M.D. Cincinnati: Central Medical Publishing Co., 1888.

THE announcement of the title page of this book is so modest as to be misleading. The ordinary conception of what is comprehended under the "hygiene of the skin" conveys no idea of the character and scope of the contents of this work which, as a matter of fact, embraces the consideration of most of the subjects usually treated of in the more pretentious and systematic text-books on dermatology.

The book is unique both in its arrangement and in the treatment of the subjects. After a consideration of the anatomy and physiology of the skin, the different diseases are taken up and their clinical features, causes and treatment described. The diseases are grouped under the headings of the different etiological factors concerned in their production as follows: Morbid impressions of the skin, embracing, 1st, individual causes; 2d, hereditary disturbances of the vasomotor nerves; 3d, hereditary disturbances of the skin, from a morbid disposition upon the part of the cells of the tissue; diathesis; skin diseases which are produced by a particular virus or virulent impressions; physiological individual conditions; other morbid affections; eruptions produced by remedial or poisonous substances; influence of diet in the production of skin diseases; external causes of skin diseases; influence of water, cosmetics, clothing, and, finally, parasites of the skin.

It will thus be seen that all skin diseases are classified according to the author's etiological conception of their nature. Recognizing that "careful study of the principal factors of these diseases can alone put us in position to prevent them," the object of the author, as set forth in the preface, is "to develop from the researches of science and from his own clinical experience the doctrine of all causes capable of producing skin eruptions."

In attempting to trace the etiology of diseases of the skin, Dr. Ravogli undertakes to elucidate the most obscure as well as the most difficult chapter of pathology. The general proposition that all cutaneous diseases result from the action of causes exterior to the organism and individual predisposition, is simple enough, but when the attempt is made to define the precise rôle played by each factor in their production, the problem is much more difficult. A morbid impression upon the skin may be entirely inoperative without an aptitude on the part of the system to conceive and develop its irritant action. Exciting and predisposing causes are so interdependent and interactive that it oftentimes becomes impossible to resolve this etiological complex into its component parts and assign to each the exact measure of its pathogenetic influence. The problem is further complicated by the existence of that etiological unknown—idiosyncrasy—which, however it may be defined, certainly exercises a modifying and controlling influence over the action of external agencies.

Many exceptions might be taken to the author's grouping of the different diseases according to his view of their etiological relations; thus eczema is classed as an "eruption of the skin from the food and from the disorders of the digestion."

An etiological classification of skin diseases is doubtless the most scientific, and will represent the ultimate advance made in this department of medicine, but in the existing state of our knowledge a satisfactory classification upon this basis is quite impossible. We all recognize that the *indicatio causalis* is an important principle in therapeutics and forms the most rational basis of treatment, but we must also admit that many of the causes of skin diseases entirely escape recognition, and that, even when recognized, they often defy control. So that we are not prepared to indorse the implication conveyed in the title of the book, that a knowledge of the "Hygiene of the Skin" is equivalent to "the Art of Preventing Skin Diseases."

**L'IODISME.** Par Elisabeth N. Bradley, Docteur en Médecine de la Faculté de Paris; Membre de la Société Zoologique de Paris. Paris: G. Steinhell, Editeur, 1887.

AMONG the notable *Theses* sustained before the Faculty of Medicine of Paris in recent years, few have received a more flattering commendation, or reflected greater credit upon their authors, than this study by Dr. Bradley of the various phenomena compended under the general term, "Iodisme."

It is characterized by painstaking, original research, a careful study of the numerous recorded observations upon this subject, and sound, logical conclusions; it constitutes a most valuable contribution to our knowledge of the physiological and toxic action of iodine and its salts.

After a short retrospective resumé of the question of iodism, the conditions of absorption by the skin, serous and mucous surfaces are examined. She then passes in review the physiological and toxicological action of iodine and its salts upon the various systems, and the phenomena which they occasion.

A considerable part of the work is devoted to the study of iodic eruptions—based upon the examination of over forty recorded cases—which possesses a special interest for our dermatological readers.

Want of space forbids the complete analysis of this work which it well merits. The conclusions are thus formulated:

1. Iodine in a natural state is absorbed by the skin, the mucous and serous surfaces. It is transported through the entire body by the circulatory channels and is eliminated by all the glands.

2. The various preparations of iodine are not absorbed by the skin, the mucous and serous membranes, intact, before undergoing a decomposition by which the iodine is set free.

3. In certain conditions of vital failure, and particularly in cases of cardiac or renal affection, or morbid nervous irritability, there may be an increase of physiological phenomena determined by the iodine, with signs of intoxication.

4. The symptoms of intoxication by iodine denote a derangement of all the functions of the organism, with a predominance in the more feeble points. They may result from a long medication or manifest themselves from the beginning of the treatment. In either case, they may break out brusquely or develop gradually.

5. Among the phenomena of intoxication the most constant is the excessive acceleration of the pulse, which, besides, becomes feeble, compressible, fleeing under the finger, and which may even disappear in grave cases.

6. This morbid condition of the pulse is not accompanied with a corresponding elevation of temperature; this may remain normal, or even descend below the norme.

7. One should search for the *raison d'être* of this failure of correspondence between the pulse and temperature in a morbid condition of the nerve centres.

8. The circulatory disorders are further demonstrated in the appearance of oedema, which may, in mild cases, be limited to the eyelids, in grave cases extend over the entire body, the glottis, the lungs, the brain.

9. The blood is altered in nature, and hematosiis does not take place under normal conditions.

10. The circulatory disorders are followed by modifications in the quantity and quality of the renal excretion. There is often albuminuria, nephritis and even hematuria; these phenomena follow a diminution in the quantity of urinary elimination or even anuria.

11. The nervous symptoms are those which belong in common to anemia and cerebral congestion, and take on sometimes the form of convulsive and comatose uremia, and sometimes the form of hypochondria or general paralysis.

12. The lungs participate in the general disorder, and, in addition to symptoms resulting more or less directly from circulatory derangements, such as bronchitis, oedema, bloody sputa, hemoptysis, etc., there is often found dyspnea, irregular respiration, apnea.

13. The disorders of the digestive system are revealed by anorexia or bulimia, nausea, vomiting, stomachal and intestinal pains, diarrhea or constipation.

14. The skin suffers in its nutrition, capillary spasm is succeeded by passive dilatation; it is the seat of various eruptions, erythema, urticaria, papular, bullous and purpuric eruptions.

15. The articulations may be involved, become painful and swollen.

This study of iodism concludes with a very complete and extensive bibliography.



## Selections.

### CONTRIBUTION TO THE STUDY OF ERYTHEMA.

DR. POLOTEBNOFF presents in a supplement to the *Monatshefte f. prakt. Dermat.* 1887 (Supl. II.), of some 200 pages, a complete study of the erythemata. Under the name of erythema we usually designate a redness of the skin, which was in former times not always clearly distinguished from the redness of erysipelas, although Sauvages clearly defined these two forms of dermatitis. Willan was the first to give a classical description of the forms of erythema, which result from troubles of the organism in general, regarding the erythemas as symptoms in relation with the various internal disorders.

Willan's works are well-known, and though nearly a century has elapsed since their appearance, the question of erythema has advanced but little, and is still one of the most obscure subjects in dermatology. It is well known that Hebra distinguishes erythema, produced by a passing hyperæmia, and with a rapid evolution from that in which the course is much longer, and which can no longer be looked upon as a simple symptom—multiform exudative erythema. He considers erythema nodosum, as a special disease, distinguished by its form, localization, course, etc., from both hyperæmic and multiform erythema.

According to the author this definition of Hebra is arbitrary, for it is not possible to mark a limit between active hyperæmia, and inflammatory exudation. The absence of exudation upon a reddened skin, does not authorize the exclusion of inflammation.

As to erythema nodosum, it is only a modification of exudative erythema distinguishable by a deeper seat, and a greater degree of intensity. Lewin has found other forms of erythema along with erythema nodosum, in twenty-five out of fifty-five cases.

In a word according to Polotebnoff, all erythemas only form one single disease : inflammatory erythema.

The etiology of erythema is still very obscure. Willan's idea that it is only a symptom of internal disease is found also among French writers. Dermatologists to-day admit that women with chlorosis and those badly nourished are often subject to erythema. Chlorosis, so often put forward, cannot be regarded as a direct cause of disease ; it is not an independent malady, but is itself brought about by various organic affections (insufficient alimentation, abundant hemorrhages, troubles of the nervous centres). The erythema is then, in such cases, not the result of the chlorosis, but a concomitant symptom of the principal disease. Coincidence of erythema with menstruation has been clearly demonstrated. Behrend has described them as menstrual exanthemata, and Kidd as uterine erythemas. Occasionally erythema develops after delivery as well as during pregnancy, and also after operations upon the uterus. Willan first called attention to the connection between erythema and stone in the bladder, irritations of the bladder and urethra, etc. Bès (1872) gives, as a cause of erythema nodosum, the soft chancre, blennorrhœa, etc. Lewin found, in forty-six cases of women suffer-

ing from exudative erythema, six instances of urethritis, two of excoriation of the orifice of the urethra, and two having both these conditions. All these erythemas are produced in a reflex way, as are also those of dentition and those observed in certain cases of diarrhoea, etc. Auspitz, influenced by the theory of angioneurosis, does not attribute any importance to irritation of the urethra. Various authors have pointed out the connection between erythema and renal and hepatic lesions. In these cases the erythema is probably developed as a result of the irritation of the centres which also provoke the other uræmic symptoms.

The author has observed a papular erythema in a case of icterus, and one of papulo-tubercular erythema in a case of cirrhosis of the liver with ascites.

Uffelmann regards as possible a connection between erythema nodosum and tuberculosis. Rheumatism has been considered as one of the principal causes of erythema. Bazin attributes it especially to arthritism. Besnier is a partisan to this view for certain erythemas. According to Sée the pains of erythema nodosum are entirely different from those of rheumatism. Hardy regards the erythema as the principal disease and the rheumatism as an accessory. Sheby-Buch holds the same opinion. Lewin says that articular rheumatism is met with only in 9 per cent., and muscular rheumatism in 18 per cent. of the cases of erythema. The personal observation of the author have led him to believe that the muscular and articular pains which accompany erythema in the majority of cases do not have a rheumatic character. He is convinced that acute articular rheumatism, considered as an infectious affection, probably general, can produce erythemas. A goodly number of authors have observed the coincidence of erythema nodosum and syphilis, and some authors admit a pyæmic and a septicæmic erythema. Erasmus Wilson attributes to the vasomotors a predominant rôle in erythema. Samuel admits a paralysis of the vasomotors having, as a consequence, a congestion of the capillaries. Duguet thinks that the pains authorize us to admit a primitive lesion of the nerve, which attacks at the same time the fibres of the vasomotors, as in herpes zoster. Pick makes erythema depend upon an affection of the walls of the vessels and a diminution in their calibre.

Lewin considers erythemas as angioneurosis and admits a complete atony of the vaso-constrictors. This theory has found convinced partisans in Auspitz and Schwimmer.

The second class of the new classification of Auspitz comprises angioneuroses, which are divided into three groups: infectious, toxic and essential. It is to this last group that all the erythemas of Willan belong.

Lewin was the first to consider erythema as an infectious disease. He described two forms: benign and malignant. The first attended with little or no fever and devoid of complications; the malignant having a temperature of 40° C., and attended with severe complications. The infectious character of erythemas is to-day admitted by a certain number of authors, but others reject it. Polotebnoff makes an analysis of all the opinions advanced on this subject during recent years and gives a clear and precise resumé of them.

He himself admits the following forms of erythema:

1. Erythema produced by external irritants; the erythema being limited to the region irritated (erythemas of Sauvages and Plenck).

2. Reflex erythemas, which develop :
  - a. After external local irritation of the skin, and do not remain limited to the region irritated, but spread over extended surfaces.
  - b. After irritation of internal organs.
3. Central erythemas, coming on after an irritation of the nerve centres (erythema of tubercular meningitis). Probably medicinal erythemas will have to be classed in this category as well as erythemas observed in kidney disease.
4. Infectious erythemas, which are found in all infectious diseases. (Lewin wished to give erythema a place by itself among the infectious diseases.)

According to Polotebnoff, all these erythemas (excepting the central and reflex) are announced by general symptoms, at times quite slight. There is always a slight elevation of temperature, and the erythema shows itself from the first to the seventh day of the disease, rarely from the eleventh to the fifteenth. The premonitory period is observed in all erythemas, and not, as some dermatologists say, only in erythema nodosum. The severity and duration of the symptoms does not depend either upon the form or on the extension of the erythema. Erythemas which have an acute course from ten to twenty days, and which do not habitually recur, are the only ones which are often accompanied by diseases of the other organs. They have almost always a prodromal stage with very pronounced symptoms on the part of the internal organs. With the apparition of the exanthem all the symptoms, or a part of them, may disappear. In certain years 90 per cent. of the erythemas observed by the author have been accompanied by acute catarrh of the stomach. Affections of the mucous membrane of the air passages are occasionally predominant. Erythemas come at times in an epidemic manner, or appear to vary in different years. It is also well-known that they are more frequent at certain seasons and in certain months. The author refers to the well-known epidemic of *erythema acrodynamicum* at Paris in 1838, and that observed in Siberia and described by Middendorf. Under the name of dengue has been described an epidemic disease which especially appears among the troops. It has a prodromal stage of from one to five days, but in about half the cases the onset is sudden. A painful enlargement of the articulations comes on with fever, temperature reaching 41° or 42° in the first twenty-four hours. The fever is continuous. In from two to seven days it disappears suddenly, often with a profuse perspiration, diarrhoea or epistaxis. The febrile condition ceases for from one to three days, then reappears, but without attaining its original intensity; it then takes on a remittent character, and gradually disappears in two or three days. The exanthem shows itself either as a roseola or as elevated papules, scattered over extensive surfaces as in measles and scarlatina, or is manifest as pomphi, analogous to those of urticaria. This exanthem is more or less complete and may be entirely wanting. Usually it appears upon the face, neck, chest, upper extremities, hands and feet. It is very itchy and terminates in a fine desquamation. In severe cases, the mucous membrane of the mouth, nose and pharynx are equally implicated. Recurrences after two or three weeks are quite frequent. The etiology is completely obscure, but the affection has a certain analogy with recurrent fever. It is not of itself fatal, but an occasional death results from complications.

Nearly all authors admit in erythema nodosum the presence of a hemorrhagic exudation, and even of a hemorrhage into the tissues of the skin and the sub-cutaneous cellular tissue. Kaposi regards it as a serous infiltration of the whole tissues of the skin and sub-cutaneous connective tissue with simultaneous stasis of the capillaries, the nodosity being only a pomphyx of excessive development. Microscopical examination, not only of erythema nodosum, but also of papular erythema, is opposed to this view, and a clinical base is difficult to find. It is impossible to consider the different varieties of erythema as simple local lesions, but we should rather admit a general process of the entire organism. It is only in infectious diseases that we habitually find a prodromal period, and a simultaneous affection of a great many organs, and which become epidemic.

It is very difficult to diagnose the abortive forms of many infectious diseases. In scarlatina we depend upon other symptoms than the rash. In variola, only eight or ten papules are found at times upon the whole body, and the diagnosis is only made easy by finding the source of infection. There is no infectious disease which always comes to its full development, always presents a typical course, which is not complicated at times with an erythema. It seems that erythema is even more often met with in the abortive forms. The various symptoms which accompany erythema depend entirely on the form and degree of development of the infectious disease of which the erythema is one of the manifestations.

The erythemas, then, do not form a special group among the infectious diseases, but represent the least grave phenomenon of the typical and abortive forms of the most diverse infectious diseases.

The clinical forms of erythema are very numerous. Some last months and years. The explanation has yet to be found. The author has observed three cases lasting many years without interruption. Until now the desquamation which follows erythema has received little attention; in some cases it is the most prominent symptom. As to the mode of regression of the nodes of erythema nodosum, although they usually disappear promptly, they may last for months or years; they rarely supurate. The author has observed suppuration but once. It is probable in cases where very marked swellings disappear rapidly, that they depended largely on inflammatory oedema and contained a relatively large quantity of embryonic cells, which are re-absorbed. In other cases, the nodosities are formed at the expense of the white corpuscles of the blood, and perhaps also of the red blood corpuscles, and resorption takes place by fatty degeneration. Erythema is always preceded by general troubles, which also show themselves during the course of the eruption. Such is not the case in eczema. The nutrition is never altered in eczema subjects when no organic complication exists. The use of the term "vesicular erythema" is defective, for there is no erythema presenting vesicles alone; nodosities and erythematous spots always accompany them, and the term "polymorphous" is preferable. Acute pemphigus presents exactly the same general symptoms as the infectious erythemas, the only difference is found in the infectious character of the general disease, being more marked than in most infectious erythemas. So far as etiology and clinical symptoms go there is complete identity between these two affections, the only difference is one of morphology. But a difference of form is not sufficient to separate two analogous diseases, any more than a point of identity can fuse them. In most cases of acute pemphigus, various forms of

erythema are found alongside the bullæ, the bullæ are then only a more elevated degree of development of the vesicles, just as erythema nodosum presents the most elevated degree of papular erythema.

The author recommends symptomatic treatment for cases of typical erythema, and quinine in cases of frequent recurrence. In vesicular and bullous forms, external and internal anti-phlogistic treatment, hot compresses changed three times daily. Unna's salicylic paste in moist plaques of medium dimension upon the trunk and extremities, hot bran baths, change of air, and rest in the country. The success of treatment in reflex and central erythemas, depends upon the relief of the principal disease (such as Bright's). A symptomatic treatment, however, may secure a noticeable relief, although it may be but temporary.—*Doyon*, in *Annales de Derm. et de Syph.*, March, 1888.

#### ATYPICAL DYSIDROSIS.

DR. VIDAL showed a patient at the Hospital St. Louis who presented an extensive raising up of the epidermis of the sole of the foot, due to confluent vesicles, which had produced veritable bullæ as large as an egg at several different points. The diagnosis would have been difficult if the palms had not shown the same elementary lesions (small vesicles). The vesicles and bullæ were caused by the extremely abundant perspiration to which the patient was subject.

Treatment consisted in the administration of sage tea, with the object of diminishing the sweat, and the local use of vinegar lotions—two spoonfuls of vinegar to the glass of water.—*Jour. de Médecine*.

#### POLYMORPHOUS ERYTHEMA.

As the name implies, this affection has a multiplicity of lesions. Among the extreme variety of manifestations is frequently found *hydroa bulleux*. Vidal has recently had in his service a case of bullous hydroa (*herpes iris* of Bateman) in which the lesions showed no trace of erythema in the neighborhood, and the name polymorphous erythema would here have been wrongly applied. In this case the bullæ not only occurred upon the skin, but the mucous membrane of the eyes, mouth and throat were involved in an extraordinary degree. The lips were swollen and covered with ulcerations, making alimentation difficult. The treatment employed was the following, as local application :

R Soda borat.....	10 grams.
Glycerin .....	15 "
Aqua lauro-cerasi.....	25 "

—*Jour. de Médecine*.

#### ADVANCES IN THE TREATMENT OF SYPHILIS.

REGARDING the treatment of primary syphilis, Neisser advances the following propositions :

1. Every local affection suspected of being syphilis must be destroyed by energetic local treatment as easily as possible, or removed by a deep incision. Even when the diagnosis is still doubtful, this procedure can only be of benefit. If there is no syphilitic infection present, the slight operation is at least harmless, and if syphilis be present it may undoubtedly be removed once and for all by excision. In all cases subsequent observation must extend over many months.

2. Well marked primary lesions should be deeply excised when their situation permits of it, as, in the author's opinion, complete cure of the syphilis may be thus brought about.

3. If no operation is undertaken, no better treatment than that of calomel and salt solution or emplast hydargyri has yet been found.

In regard to constitutional treatment the following conclusions are formulated :

1. Constitutional treatment must be one of mercury. Mercury is the only drug which attacks and destroys the syphilitic virus. All other means and methods are only adjuncts.

2. The constitutional treatment must never be begun before the diagnosis is firmly established.

3. Constitutional treatment must never be considered as completed before the fourth year of the disease, whether symptoms continue to show themselves or not. It consists in frequently repeated energetic cures and milder after cures, separated by intervals of weeks or perhaps of months according to the constitution of the patient and the course of the disease.

The most agreeable and most easily carried out method of treatment is that by the internal administration of mercury.

Injections with the soluble salts of mercury, although their action is more sure and more marked than in the internal administration of the drug, are not so valuable as inunctions. The author considers the injections of calomel as an advance step, not yet sufficiently appreciated, its especial advantages being

1. The ease and comfort of the method ; four to six injections at intervals of from eight to ten days.

2. The surprisingly rapid and sure results. In respect to the efficacy of this method it is regarded as superior to that by inunction. Inflammatory nodules at the point of injection are reduced to a minimum by the suspension of the calomel in oil. (Calomel vapor, parat, 1,00, ol. oliv. 10, one cubic centimeter for each injection.) It is well to keep in mind the local treatment of all syphilitic eruptions and glandular enlargements at the same time that constitutional treatment is employed. In the dry papular and squamous forms, emplastrum hydargyri may be used and chrysarobin will often be found useful. Mucous patches may be touched with a solution of corrosive sublimate in tincture of benzoin (1 to 100). In ulcerating lesions the subiodide of bismuth is more efficacious than iodoform, and iodol does not work so well.

For stomatitis, such astringent tinctures as rhatany, galla, myrrh, etc., are useful, with an addition of a few drops of oil of peppermint. In salivation the early employment of atropia is recommended. In mercurial ulceration, hydrobromic acid is the best.

In regard to the use of the iodide of potassium, the author believes in the necessity for large doses in severe forms of the disease. Six, eight or ten grams of the iodide of potassium, or of sodium, being necessary and well borne, especially when taken in milk. Iodol works more slowly ; it may be given in half-gram doses, four times a day. Slight iodism does not necessitate cessation of treatment, but it may become necessary to give the bromide of potassium or the extract of belladonna at the same time. He believes in the advantages of the combined or mixed treatment. Baths, sweatings and water cures are only aids to the mercurial treatment.

During pregnancy, energetic measures must be employed to prevent transmission of the offspring.—*Centraltb. für Chirg.* March, 1888.

### VAGINITIS.

VIDAL has found the balsam of Gurjun one of the best substances in treating vaginitis. Tampons soaked in a mixture of two parts of lime-water and one of the balsam are introduced within the vagina. Some irritation and burning sensations are at first experienced, but soon disappear. In gonorrhœa Dr. Vidal employs the balsam of Gurjun internally as well.

THE following formula is applicable to certain cases of dry eczema giving rise to excessive itching :

R Glycerole of starch..... 30 grams.  
Tannin.....  
Calomel.....ââ 1 gram.

The glycerine must be very pure or the preparation will be irritating.—*Jour. de Médecine.*

### ECZEMA OF THE EAR.

POLLITZER, of Vienna, describes two cases of this often obstinate affection, one being of the vesicular, the other of the squamous variety. The method of treatment is noteworthy. All sources of irritation, such as water and contact of air, must be eliminated, and the parts kept covered with emollient ointment, or vaseline. In post auricular intertrigo calomel is to be dusted on, care being taken not to introduce it into the canal. Cocaine, in 5 per cent. solution, may be applied on compresses where there is much pain, and ichthyol may be used in a watery or alcoholic solution (1 to 50), or as an ointment (1 to 10). Crusts must never be removed roughly, but only after softening with balsam of peru, when their removal with dressing forceps may be effected. Raw surfaces are to be covered by means of a soft brush, with Hebra's ointment; emollient ointment with vaseline; boric ointment, 1 to 15; zinc ointment, 1 to 30; Lassar's paste, etc. All affected regions must be well covered with the ointment, and kept in close contact with it by a few turns of a bandage. Eczema squamosum of a light grade gets well under repeated applications of tinct. rusci., carbolized spirits, 1 to 30; spir. borici, 1 to 20, and washings with tar or soda soap. Severe forms, with thickening of the epidermis and infiltration of the skin, must have daily application of emplast. saponis. salicyl. (10 or 15 to 100) and ol. rusci or ol. cadini, well rubbed in with a stiff brush. If the skin becomes softer, painting over the part ol. cadini, cum glycerine, 1 to 25, or a salve composed of flowers of sulphur, oil of cade, and liquid storax ââ 10 pts., or equal parts of ung. diachyli and olive oil; or ichthyol ointment, 1 to 10, carbolic ointment, 1 to 40, or ointment of the white precipitate will give good results.

In squamous eczema of the external auditory canal applications of concentrated nitrate of silver solutions effect a good purpose. After a cure has resulted, the canal should be painted twice a week with oil of cade and vaseline 1 to 40. Internal treatment is often necessary, and arsenic and cod-liver oil will be found useful.—*Deutsche Med. Zeit.*, No. 17, 1888.

### LITHOTRITY WITH THE AID OF COCAINE.

CASES are still few in number in which cocaine has been used to obtain anesthesia and distension of the bladder, to permit the necessary manipula-

tions of lithotrity. Weir and Otis, of New York, Watson, of Boston and others have reported successful use of the drug in genito-urinary surgery.

Dr. Philip reports in the *Lyon Medical*, October 9, 1887, the case of a patient 73 years of age, who three years ago suffered retention of urine after much walking, since then he has had nocturnal incontinence and painful urination, after fatigue, and copious repasts.

Early in 1887 the urinary troubles increased, urination became more frequent, as often as every half hour, the last drops being attended with pain. The urine was somewhat purulent, contained albumen and a trace of sugar. The prostate was the size of a hen's egg. The metal explorer always became engaged in the interior of the bladder, and did not detect any stone, but the soft catheter gave a sensation of rubbing against a hard substance. The diagnosis of several friable calculi was finally made, the patient suffering severely from the examination, only being able to bear for a few moments an injection of about an ounce and a half of boric solution. Here then admitting that lithotrity could be done at all, it could not be carried out without danger. Anæsthesia was not practicable, because of a previous attack of apoplexy, and a functional affection of the heart. Cocaine was therefore used, and the results surpassed all expectations.

So long as the mucous membrane of the bladder is intact, there is no danger from absorption. The danger becomes the greater, the more complete and extensive is the desquamation of the epithelial layers. The quantity employed must therefore vary with the amount of alteration present. The first symptoms of intoxication which have at times been noted after cocaine, have but rarely been prolonged when rapid evacuation of the solution has been affected, followed by washing out the bladder. In this case weak solutions were first used and progressively made stronger until the effective, and non-dangerous dose was reached. One gram gave no results, and 3 grams were found requisite to cause sufficient anæsthesia to permit of distention. This was injected in 40 grams of distilled water. Ten minutes after the injection it was possible to inject 10 ounces of water containing boric acid, without the least painful sensation being felt. Three lithotrity sittings were necessary. The first lasted twenty minutes, and caused no pain. In the second Bigelow's aspirator was used, and a slight pain was felt. No bad results followed. The debris weighed about 300 grains, and was mostly removed at the first sitting.

### SALICYLATE OF MERCURY IN SYPHILIS.

DR. ARANJO, of Rio de Janeiro, gives the following resumé of his use of the salicylate of mercury in the *Bulletin General de Thérap.*, Feb. 29, 1888 :

1. Salicylate of mercury is well borne by the stomach. The gastralgias, enteralgias and diarrhoeas, which are produced by the other preparations, not excepting the protiodide, do not occur when this preparation is used.

2. In the dose indicated (25 milligrams), stomatitis is never produced.

3. Its internal use acts more promptly and more energetically than other preparations of the same base.

4. Externally, it presents the great advantages of causing rapid cicatrization of mucous patches and all ulcerative processes. It furthermore causes re-absorption of non-ulcerating syphilomata (papules, tubercles, gummata).



5. In parasitic dermatoses (eczema marginatum of Hebra, circinate pityriasis of Vidal, parasitic sycois, pityriasis versicolor, tinea favosa and tinea tonsurans) the salicylate of mercury offers the advantages over other preparations of being without odor and non-irritant when the strength is proportionate to the nature of the affection.

6. The salicylate is efficacious in the most inveterate forms of syphilis, and the author believes it will soon replace the protoiodide, the bichloride and the tannate.

7. In the treatment of lepra, it has given very encouraging results associated with gynocardic acid (active principle of the oil of *gynocardia odorata* or *chaulmoogra*).

8. It has given excellent results in acute and chronic blenorrhagia.

The author knows many colleagues in Rio who have also used this preparation, and speak well of it.

### IMMEDIATE SUTURE OF THE URETHRA IN TRAUMATIC RUPTURE.

OPINIONS are at variance regarding the treatment of the most severe cases of rupture of the urethra, and antiseptic treatment has not as yet produced the beneficial modifications which were hoped from it.

In complete rupture of the perineal urethra, a rational method of treatment should, according to Erasme (*Annale des Maladies Genito-Urinaires*, March, 1888), fulfill the following indications :

1. To open a wide passage for the fluids which have accumulated about the point of rupture.

2. To maintain free vent to the urine.

3. To bring about rapid union of the two ends of the ruptured urethra and the walls of the cavity formed by the extravasation into the perineum.

4. To prevent the formation of cicatricial contraction of the urethral canal.

Antiseptic treatment, carried out according to the rules indicated by Hueter and Löbker, by fixing an elastic catheter *à demeure*, and by antiseptic packing of the wound (Iversen), or by suture of its borders (Lucas-Championnière) in producing a more rapid union, and a less developed inflammatory new formation, diminishes a little the retractility of the peri-urethral tissues, but does not prevent the cicatricial retraction of the newly-formed portion of the urethra.

We cannot hope for a complete and lasting result excepting in the immediate re-union of the two extremities of the urethra, without interposition of new-formed tissue. In complete rupture can we hope for union by first intention ? This problem has been carefully studied in an experimental and clinical work by Kaufmann, of Munich. He experimented upon dogs, and found that primary union was possible under most conditions. The borders of the mucous membrane must be carefully and exactly sutured by points of catgut, and the catheter removed, as it will prevent perfect antisepsis, catheterism being practiced only in the first days. The perineal wound is to be dressed open and covered with an antiseptic bandage.

When there is much separation of the two extremities the elasticity of the canal will undoubtedly permit of approximation and complete union. Mollière and Koenig found that union would take place after a considerable section of the canal had been removed.

The author thinks Kaufmann's proposition, to apply to man the immediate suture, is perfectly justifiable. The following case is related : A young man of 38 fell upon a barrel, striking the perineum ; he had retention, tumefaction of the scrotum, blueness of perineum, and swelling and persistent hemorrhage from the urethra. Diagnosis—Severe rupture of urethra. A median incision was made in the perineum from the margin of the scrotum almost to the anus. Beneath the superficial aponeurosis was found a cavity filled with clots and urine, and extending nearly to the symphysis pubis. The tear could not be discovered, so the urethra was incised longitudinally upon the point of a catheter to one side of the bulb, and complete division of the canal was found in a transverse direction, simulating a simple incision without much contusion. The tear was sutured with catgut, and the bulbo cavernous muscles which had been torn across at their insertion were sutured to the transverse muscles. Iodoform dressings were applied and a permanent catheter introduced. Drainage with an elastic tube and drugs to cause constipation. On the third day the catheter was changed, and union was apparent in the upper two-thirds of the wound. By the twelfth day the wound was nearly healed, and no urine has escaped by the perineal opening for five days. The catheter was removed and urination was freely established, and two weeks later the patient was discharged. The reunion of the canal was rapidly effected in this case, although some urine had escaped through the wound. The sutures were not applied to the mucous membrane directly, but close to it in the submucous and cavernous tissues. Kaufmann's sutures included the mucous membrane and were tied inside the canal, but the operation here carried out appears to the author to offer more probability of success. It is requisite that the points of suture in the perineum be separated so as to assure discharge of the secretions and urine which may escape through the sutured urethra. Rigorous antisepsis is necessary. Immediate suture is regarded as preferable to the late suture of Mollière, and according to Kauffmann, finding the posterior extremity of the urethra is more difficult than in recent cases. Kauffman's statistics give a mortality of 8.79 per cent. for cases treated by early perineal incision ; 19.04 per cent. for cases treated by the hypogastric puncture, and 20 per cent. for those treated by the late perineal incision. It is probable that the differences would be still more marked for suture of the urethra.

#### TREATMENT OF FURUNCLE AND CARBUNCLE.

At the meeting of the Academy of Medicine of Paris, January 17, 1888, Dr. Verneuil made a communication upon the treatment of furuncle and carbuncle by phenic acid spray. The following conclusions were drawn :

1. Furuncle and carbuncle are only different degrees of the same infectious process and are susceptible to the same therapeutic measures.
2. These consist in surgical operations and topical applications. The first seemed formerly indispensable or at least applicable to the majority of cases. The second, efficacious in the main, in the lighter cases, only played a secondary rôle.
3. The opposite view should be accepted to-day ; operative interference becoming less and less necessary, being reserved for the exceptional cases. On the other hand topical antiseptic applications in the first rank of which we must place phenic and boric acid solutions used in a certain way, particularly in the form of prolonged and repeated sprays. Their efficacy being

noteworthy at the same time that they are absolutely benign and easily applied.

4. Sprays with very few exceptions cause rapid abortion of the furuncle and small carbuncles, and in the more severe cases arrest the progress of those diseases. The pains are quickly calmed, the fever and sequelæ diminished, and the disinfection of purulent and gangrenous points hastens healing.

5. The treatment is applicable to all regions, to all forms and to all periods of the disease. It is never harmful and, alone effects a cure in the majority of cases. If surgical intervention become necessary, sprays aid greatly in the cure.

6. Finally internal anto-inoculation and symptoms of general infection are prevented.

The patient's body and clothing are to be protected by towels, etc., and the immediate neighborhood of the lesion by pieces of diachylon plaster, card-board or the like perforated for the furuncle or carbuncle to pass through. The patient's position should be made as comfortable as possible, so that only the benefit of the spray will be made note of.

A number of illustrative cases were reported. Small alcoholic spray producers, acting for twenty-five minutes are sufficient for light cases, but larger ones throwing a more powerful spray are required for the more severe one. The distance is regulated by the sensation of the patient. A two per cent. solution is advised. Two hours of treatment a day is usually sufficient at intervals, and of duration to suit the case and the patient. In the interval of spraying a compress wet with the same solution is applied.

In the discussion which followed,

LE ROY DE MÉRICOURT thought that the bacterial origin of furuncle was not yet demonstrated, and that its etiology was complex. If Dr. Verneuil believes that the phenic acid acts as an antiseptic, why would it not be preferable to inject it around the anthrax, as is done with the tincture of iodine in malignant pustule, thus more rapidly securing antiseptics? Perrin employs prolonged hot-water baths, replaced during the night by cold starch cataplasms.

LE FORT thought that the phenic acid must act especially as an anæsthetic. In a certain number of cases, it is not easy to avoid surgery.

LABORDE thought that the action of the phenic acid was not alone that of a microbicide, for it exercises an influence upon the contractibility of the capillary vessels.

TRELAT thought anæsthesia was only produced when the acid was used in strong solution. In anthrax of a severe type in profoundly debilitated subjects, he thought Verneuil's process was insufficient, and that we must resort to the knife.

MARC SÉE believed the method applicable with advantage to timorous individuals, who dreaded cutting instruments. Carbuncles, accompanied by severe general symptoms or threatening to become very large, are best and most expeditiously treated by cutting.

HARDY regards furuncle as a light affection, but subject to frequent recurrences. He had employed the spray treatment in a furuncular abscess of the lip. Furunculosis may persist for many years, and a strict regime and treatment with alkalies, tarry preparations and arsenic, be necessary. As to the bacterial nature of furuncle, we certainly find micro-organisms but only as a secondary affair. The furuncle is only a small cadaver, upon which micro-organisms develop.

VERNEUIL said he had cured very large carbuncles with the spray, and urged its thorough trial before the method was condemned as ineffective.

Commenting upon Verneuil's paper, *Le Progrès Médical*, recalls a contribution in *La Loire Médicale*, in which Montagnon says, that the treatment of furuncle must vary with the period of its existence. At first when the microbe, which is the author of the evil, has not yet penetrated beyond the skin, parasitocides may prove abortive, or at least modify the severity in a marked degree. If in eight days the lesion extends in depth, the bistoury or the thermo-cautery must be used, followed by antiseptic solutions.

Boucharde has cited cases where a furuncular eruption has been arrested by intestinal antiseptics. Le Gendre (*Le Concours Médical*, January 28, 1888) has applied this treatment with marked success, administering thirty centigrams each of Beta naphthol, salicylate of bismuth and magnesia, every four hours. Local antiseptic washes were used at the same time. The author believes in the causative agency of micro-organisms, and that antiseptics of the intestinal canal may prevent repeated outbreaks.

Dr. Bockhart, of Wiesbaden, believes after a series of careful observations, that furuncle, sycosis and impetigo, are but different forms of one and the same process.

The staphylococcus pyogenes aureus et albus, was found in impetigo and also in boils. Cultures were made and impetigo produced upon his own person by inoculation, a crop of pustules within twenty-four hours. The pus from these contained the same organisms. Two pustules which were perforated by hairs, became boils. The same cocci were found in five cases of sycosis. Cocci which have penetrated the skin are removed by the white blood corpuscles. Pastes and ointments which hinder the escape of pus from the lesions, are not to be used. In sycosis, epilation is practiced, and corrosive solution, 1 to 1,000, or 1 to 2,000 is used. He does not favor injection of antiseptic fluids into the substance of the boil, since it is painful and without value. Sublimite baths were not found to prevent fresh attacks of either impetigo or boils.

In a clinical lecture on the treatment of carbuncle by scraping, Dr. Page, surgeon to the St. Mary's Hospital (*Brit. Med. Journ.* March 24, 1888), says that in some cases debility leads originally to carbuncular inflammation, and this in turn increases the debility, until the patient's condition may be one of great danger. You will find in text-book how to keep up the strength, but little satisfactory as to local treatment. Paget has arrived at the general conclusion that the best of all treatment is to "do nothing," understanding that his patients were "carefully fed, washed, cleansed and bedded, and their carbuncles skilfully dressed, washed and every care taken to shut out all untoward influences from them." No active surgery, no incisions, no medicine or anything of that kind. During this slow process of slough separation, the patient has much to contend with, and is subjected to many risks. There may be exhaustion, pain, septicæmia and pyæmia, and it is from one or the other of these last conditions, that death commonly ensues. This risk may be avoided by the free removal of the carbuncle by scraping with the Volkmann spoon or Lister's scraper. There is not much bleeding and no danger from this score. The patient is anesthetised, and after all sloughing tissue has been scraped out, the wound is irrigated with perchloride or carbolic solution, dusted with iodoform, and dressed with some pres-

sure wood-wool pads. A case is recited in which in five days the surface was covered with healthy granulation. Others in patients aged 65 and 55 years in which good recoveries took place. The author claims great advantage in getting rid of sloughs of this nature as quickly as possible. You may remove them too late, you can hardly do so too soon.

Mr. Teale says in the *Liverpool Med. Chir. Journal*, January, 1887 : "Probably in no disease involving severe pain, and occasionally threatening life, is treatment by scraping more conspicuously of value, than in carbuncle ; the main attack should be supplemented by smaller crucial incisions and scrapings in the contiguous carbuncular skin. Having rid the mass so far as possible of all diseased, decaying, infecting material, the resulting cavities and crevices should be well soaked, either with pure carbolic acid, carefully used, or with the glycerole of carbolic acid, so that every crevice where half dead tissue remains, may be soaked and penetrated. Finally the raw surface is well charged with iodoform, and dressed with salicylic acid or some such absorbent antiseptic material. The result is cessation of pain and feverishness, restoration of normal temperature and a rapid establishment of comfort, convalescence and healing."

In the same number of the *Journal* Dr. Cole reports a case of double carbuncle over the shoulder blades, each five inches or more in diameter, in a much reduced patient. They were scraped out at the St. Mary's Hospital, dressed in the usual way. The man began to pick up from the date of operation, and was soon well under tonic treatment.

Mr. Owen, in whose service the case occurred, was much pleased with the results of scraping in what he considered an unfavorable case. He thinks there is less likelihood of harm from too early interference in anthrax (carbuncle) than in acute necrosis, and is strongly of the opinion that radical treatment is a distinct advance.

### THE QUESTION OF CONTAGION IN ALOPECIA AREATA.

THE views of the medical men to-day regarding the question of whether or not alopecia areata is a contagious disease, are apparently as much at variance as they were years ago, when Bateman pointed out the difficulties. The question is one of great practical importance, and we are not surprised to find the French Academy of Medicine devoting several meetings to its consideration.

Dr. Ollivier, upon whose paper the discussion is based, believes that alopecia is but slightly or rarely contagious, and that the exclusion of children from the schools on account of it is an unwarranted hardship. This exclusion from the public schools has been practiced in France since 1879, when Delpuch reported that *la pelade*, the most innocent of the tinea, is perhaps the most dangerous, because it may for a long time escape notice. A child with thick hair may have one or more denuded plaques without attention being called to it, and while thus perhaps himself unconscious of his affection, might communicate it to his comrades. The two most common means of propagation in the schools are the habit of changing hats and caps at play, and the common use of brushes and combs.

Lallier has recently said : "This disease is less contagious than favus and tinea tonsurans, and there are even many of the most competent physicians who believe that it is not communicable ; but as there are incontestable

ble examples of transmission to a number of children in educational establishments, it is more prudent to exclude those who are attacked."

Almost every one believes that there are two forms of alopecia, one of which at least is not contagious, but no such distinction is made for the schools.

Since a previous communication, in February, 1887, Dr. Ollivier has collected thirty observations, which he gives to show that the patients had neither contracted the disease from others nor given it to any one, so far as could be learned.

Cornil agreed with Ollivier that alopecia areata was not contagious, the more so because no micro-organism could be found as the agent of transmission.

Hardy said he based his opinion that the disease was contagious upon his own observations and those of many others, and did not think that failure to find the micro-organisms was a valid objection, as Cornil had probably never seen the micro organism of scarlatina and measles, and yet could not deny their contagious nature. He believes that there must be a receptivity on the part of the person attacked. If epidemics have become rare in the schools, it is because of the strict rules which the author of the paper would abrogate. Last Spring one of the regiments received two recruits who had alopecia areata, and before the end of the year 120 soldiers of the regiment had apparently contracted it, eighty having it in a well-marked degree. It was found that all the soldiers had had their hair cut with the same clipping machine. This was suppressed and the epidemic disappeared. In the same way an epidemic in the Lycée of Amiens, where out of 400 students 50 had the disease after a similar hair-cutter had been used. Several similar epidemics are cited; one in which the porter of a house, just after the siege, gave it to the valet, the valet to the master, and the master to his son. A soldier with a bald spot leaves the service, and his cap is given to another soldier. Fifteen days later this soldier presented a spot of alopecia exactly where the first man had had his.

Another instance, in which fifteen days was the time between the arrival of a boy with the disease at a farm-house, and the appearance of the disease in the farmer's two sons, is quoted.

The argument drawn from the experiments in which a nerve has been cut in animals, and been followed by falling of the hair over the region supplied, does not prove anything against the contagiousness of alopecia areata but only that the same falling of hair can take place under the influence of different causes. In these particular cases we evidently have a trophoneurosis; after the nerve is cut the hairs atrophy, just as the skin, fat, muscles, etc., do. Besides, there is only one cause for a general alopecia, why should it not be the same for a partial alopecia? Bazin admitted that there might be two kinds of alopecia, one contagious, and one nervous, this maybe so, but they cannot be distinguished from each other, they have the same symptoms and the same course. In 1875, before the report was made by Delpach to the Council of hygiene and public health, an epidemic of this disease broke out in the small college of Vanves. Hillairet and Hardy were sent by the minister of public instruction to investigate and report measures of preventing similar outbreaks. They found the disease existing and recommended that all students have the hair cut short on entering, and that the attending physician examine all students heads every fifteen days and as soon

as one was found with alopecia areata or herpes tonsurans he should be sent home. This advice was acted upon, and since this time epidemics in schools have not been so frequent.

Dr. Ernest Besnier said that the contagion was not a constant one, nor was the disease necessarily contagious to all persons, and at all periods. All persons are not susceptible and this is one reason why so many observers differ. He then cited many curious coincidences from his own practice, where husbands had shown the disease after the wife had developed it, and where physicians taking care of alopecia subjects had themselves subsequently suffered an attack.

Dr. Toledaud published in the *Bulletin Medical*, December 25, 1887, a case of a boy whom he had sent home from a school on account of the disease. Subsequently he was returned with a certificate from a professor of the Faculty stating that the disease was not contagious. Fifteen days after his admission, three other boys of his own class had the disease. All four boys were now sent home and no other cases developed.

The source of contagion is often obscure, but because we cannot trace it we must not let it weigh against the positive results produced.

Ollivier maintains that alopecia areata is more often due to a trophoneurosis than is supposed, and the influence of fright, grief, etc., he believes is well shown in many of the 130 cases he has observed.

Fournier thought the discussion could have no issue. It is impossible at the present time to actually fix upon the contagion. There are excellent observations for and against contagion. Three of the students at the St. Louis hospital who treated these cases had recently had the disease themselves. He thought the disease increasing in frequency of late years. A special commission was appointed by the president of the Academy to inquire into the disease and the measures necessary to be taken.

In connection with this lengthy and somewhat fruitless discussion we would recall to our readers the bacteriological observations of Von Sehlen, Eichhorst, Lassar, and those of Robinson and Ravogli, of this country, presented at the last Congress in Washington.

Bender (*Monatshfte für prakt. Derm.*, January 15, 1887) has observed the coccus of Von Sehlen, but says he has found the same in his own and other healthy hair. Inoculation in animals has given negative results. The author thinks that the parasitic doctrine loses little by little, and believes the disease to be a trophonemosis.

Schachmann (*Ann. de dermat. et de syph.*, March 25, 1887) thinks purely anti-parasitic treatment acts very slowly if it acts at all.

Besnier epilates around the patch, but employs excitants, such as acetic acid alone or mixed with chloroform.

Lailler uses stimulating lotions with ammonia as a base.

Vidal as early as 1861 advised the use of blisters, left on until bullæ formed, then a simple dressing. This repeated from three to ten times. The rest of the head being rubbed morning and night with :

R Spt. Terebenthinæ.....	20. pts.
Ammonia. ....	5. "
Aquæ.....	100. "

The author gives twenty-nine observations in which this treatment was successful usually in less than two months, no cases lasting over three months after treatment was begun.

### TREATMENT OF PSORIASIS.

IN spite of all new forms of treatment introduced from time to time for the cure of psoriasis (some of which have their special application for certain cases), Vidal believes (*Journ. de Méd.* No. 10) that for the generality of cases we find in the oil of cade a superiority which forces us to come back to it again and again. By its use it would appear that recurrences are less frequent.

The following formula is given:

R	Glycerole of starch .....	100
	Green soap .....	5
	Oil of cade .....	100

This makes a soap much more easy of application than the oil of cade alone. It should be applied each night, and a flannel night-dress worn, which is only changed at long intervals. In the morning a bath with tar soap is to be taken, and, if desirable, the odor of the tarry preparation is removed with some perfume.

### THE VARIOUS MODES OF TREATING STRICTURE.

ANTAL thus concludes his article in the *Vierteljahresch. für Derm. und Syph.*, 1887, No. 4.

1. We should endeavor to make out the stricture, so far as possible, in the inflammatory stage, as only in this case can a lasting result be obtained without danger of recurrences.

2. We should choose, if possible, the method of operation which conforms to the stage and nature of the stricture, which we can determine by external touch and examination with the sound, after proper dilatation by means of the endoscope.

3. In regard to the treatment of an inflammatory stricture, he regards gradual dilatation, followed by mild cauterization, as the most appropriate means.

4. In connective tissue strictures, temporary, and where feasible, constant dilatation gives very favorable results, without presenting the dangers of frequent returns.

5. At the end of the dilatation process and cessation of the mechanical irritation, he thinks it advisable to examine the region by means of the endoscope, and if it discloses a gonorrhoeal process still existing at the point of stricture or near it, to supply appropriate treatment, and with this precaution we can often prevent rapid and severe recurrence of the stricture.

6. In calloused strictures, if we could, by hot applications, baths and massage, bring about resorption of the connective tissue hypertrophy, we might secure even such good results from temporary dilatation, as in connective tissue strictures. If, however, the callous stricture cannot be resorbed, the indications for urethrotomy are present, and, according to my views, the external is to be preferred to the internal operation. Where peri-urethral ulcers, false passages or fistulæ are present, as complications, external urethrotomy is decidedly the operation to choose.

7. Ring-formed connective tissue strictures of small calibre, situated near the external orifice of the canal; strictures springing from ulcers and valve-like strictures are most simply relieved by internal urethrotomy.

8. Cicatricial strictures brought about by traumatism, are best treated



by external urethrotomy, where the removal of the cicatricial portion of the urethra in all such cases is an assured advantage, where the entire re-union of the urethral mucous membrane is practicable, where, however, on account of the extent of the cicatricial tissue, this cannot be carried out, we must be prepared to have severe recurrences after external urethrotomy.

9. Stretching a stricture (divulsion), whereby the healthy, or rather, the more healthy parts of it are wounded, ruptured and bruised, and so lead to traumatic and cicatricial strictures, is, in his opinion, always to be avoided.

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### Items.

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**FURROWS OF THE NAILS.**—At the London Pathological Society, Dr. Wilks showed drawings of the finger nails of a man aged 50, who sailed for America, August 28, 1887, and returned October 18th, of the same year, being sea-sick for three days in each passage. Two furrows subsequently appeared on his nails, which exactly corresponded with the dates of his sea-sickness. The author had described the production of these furrows in a paper published about twenty years ago. The furrow is shallow when near the lanula, and difficult to identify, but it reaches the middle of the nail about three months after an illness. Dr. Wagstaffe had described to him the case of a man whose arm was kept in a splint for some time, and the furrows had affected this side only. It was said the number of calves a cow had had could be told by counting the rings on the horn. Dishonest drovers are said to file them down. Mr. Lutton said, after a severe winter the feathers of wild birds were stunted, and birds in confinement, when badly fed and cared for, showed stunted feathers after the next moult. Mr. Sedgwick mentioned a family in which marked transverse ridges formed across the nails of the females at about the age of 52. Mr. Bowlby said that nerve injury was often followed by deformity of the nails. Sir James Paget, the President, said that, in his own person, every severe illness was followed by a furrow. Dr. Wilks's case was valuable, as showing how short an illness might produce a furrow.—*The British Medical Journal*, March 24, 1888.

**RECURRENT HERPES** of the tongue in syphilitic subjects has been observed, often several years after the apparent cure of the syphilis. It appears as erosions upon the sides of the tongue, and is characterized by the slight effect produced upon it by antisyphilitic treatment, and its great tendency to recur after cauterization and similar local treatment. Fournier says (*La Semaine Medicale* 1887):

1. The affection appears only in the form of erosions or superficial exfoliation, of the mucous membrane.
2. The erosions are small, averaging in size from a lentil to a grain of corn, and some are scarcely the size of a pin's head.
3. The erosions are numerous and scattered, and, although usually on the edges, are also found upon the dorsum of the organ.
4. Like herpes, the erosions are only of short duration, eight to fourteen days, if no unfavorable conditions are present, such as smoking and a general unhealthy condition of the mouth.
5. The constant tendency to recurrence favors the theory of herpes.

6. The herpetic character is marked in the polycyclic configuration of the lesions. The color of the lesions is somewhat red, but, before the epithelium is removed, is rather grayish. The reason the lesions are not met with in the vesicular stage is because of the ephemeral character of the vesicle. The author thinks the condition due to the irritation of the mucous membrane of the mouth from excessive use of the mercurials, the use of tobacco, etc. Hence, a mercurial course only makes the condition worse, and he cannot regard it as a syphilitic manifestation.

**EXTENSIVE BURNS** are best treated according to *Le Clerc* (*Journ. de Méd.*, March 1888), by the continuous bath rendered antiseptic with carbolic acid and kept at a temperature of about 95°.

**EXCESSIVE PERSPIRATION** of the feet of years duration and so disagreeable to the patient that he thought of suicide, was cured by Legoux (*Gaz. Méd. de Picardie*) in fifteen days, by applying twice a day the following mixture, after the feet had been bathed during several days in a weak infusion of walnut leaves :

R	Glycerine.....	10 grams.
	Perchloride of iron.....	30 "
	Essence of bergamot.....	20 drops.

**VARIOLA.**—Dr. Carailou pursues the following method to allay suppuration, hasten healing and prevent pitting in small-pox. About the fourth or fifth day he opens the pustule with a lancet or needle, wipes away the fluid with antiseptic cotton, which is at once burned. He then applies with a small brush to each pustule :

R	Benzine.....	1 gram.
	Water.....	40 "
	Alcohol.....	2 "

In the third stage he prescribes to be applied :

	Naphthol.....	5 grams.
	Vaseline.....	100 "

*Journ. de Méd.* March, 1888.

**CREOSOTE INJECTION** for gonorrhœa is praised by Turpura Impalamenti, especially in combination with boric acid, etc. He uses a one per cent. solution in decoction of camomile. The author says he has seen moving bodies within the pus cells twenty-four hours after the discharge began, and two hours after using the creosote found the microbes dead. Five out of seven patients were cured in six days.—*Farm. Italiano*.

**ISOLATION OF CONTAGIOUS DISEASES.**—In the French schools children affected with contagious diseases, are strictly isolated from the first day of invasion. For variola and scarlatina, forty days is the time prescribed by Ollivier, acting for the section of hygiene of the Academy, and twenty-five days for varicella and measles. Several baths with soap are taken before the patient goes out, and especial attention is given to cleansing the hair and scalp. The clothing is carefully fumigated and disinfected.—*Le Progres Médical*, January 28, 1888.

**PRELIMINARY LOCAL TREATMENT OF PSORIASIS.**—First of all in the treatment of psoriasis, the scales must be removed, and for this purpose soapy lotions have been advised, also simple and alkaline baths, etc.

In France the scales are made to fall by means of alternate baths of starch and vapor baths, followed at night by the application of caoutchouc. It must be noted that the whole body must not be covered at once, nor suddenly, but that it is more prudent to make partial impermeable coverings. Every psoriatic patient has not the means or time to resort to baths, whose effect by the way are not rapid. We therefore recommend as a simple, and rapidly efficacious means within the reach of all, the following ointment to be used twice daily :

R Carbonate of ammonia.....	10 grams.
Lanoline.....	25 "
Cold Cream.....	50 "

This ointment does not produce any pain, is irritating, and causes the crust to disappear, leaving the surface smooth and free, giving an opportunity for other agents having a direct and real action upon the affection proper, to act with certainty.—*Archives de Méd. et de Chirg. Prat.* 1887-88.

#### **SYPHILIDES OF THE VULVA.—**

R Chloral Hydrate.....	5 grams.
Tinct. Eucalypti.....	10 "
Aq. Destilat.....	500 "

To apply to mucous patches and ulcerating syphilides of the vulva and other parts.

#### **PIGMENTATIONS IN PREGNANCY.—Dr. Monin recommends :**

R Cacao butter.	
Castor oil.....	āā 3 iiss.
Oxide of Zinc.....	gr. v.
White Precipitate.....	gr. ii.
Essence of rose.....	gr. ii. x.

M. S. Apply morning and night.

**DERMATOLOGICAL INSTRUCTION ABROAD.**—The advantages of Professor Unna's instruction is offered to those who wish to take a complete and thorough course in dermatology. Under his personal supervision physicians and students are instructed in the microscopical, bacteriological, clinical and therapeutical investigation of skin diseases. His course comprises not less than six months' study, and is to be commended as possessing decided advantages over the four weeks' courses given in Berlin and Vienna. To those contemplating dermatological study abroad, all requisite information can be obtained by addressing Dr. P. G. Unna, Hamburg.

#### **PRELIMINARY PROGRAMME OF THE AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS. AT THE MEETING TO BE HELD IN WASHINGTON, SEPTEMBER 18, 19 AND 20, 1888.—**

1. Clinical Observations on Diseases of the testicle. By Dr. L. B. Bangs, of New York City, N. Y.
2. Clinical observations on Chronic Gonorrhœa, and
3. Two cases of Cancer of the Seminal Vesicles, with pathological specimens. By Dr. J. P. Bryson, of St. Louis, Mo.
4. Operative Treatment of Hypertrophy of the Prostate, and
5. Case of Bowel ending in the Urethra of a child four weeks old ; relief by operation. By Dr. A. T. Cabot, of Boston, Mass.
6. On the Effects of Rapid Changes of Altitude in an Advanced Case of Interstitial Nephritis. By Dr. George Chismore, of San Francisco, Cal.

7. Connection between Masturbation and Stricture. By Dr. S. W. Gross, of Philadelphia, Pa.
8. Operations on the Kidney. By Dr. W. H. Hingston, of Montreal, Canada.
9. Syphiloma of the Vulva. By Dr. J. N. Hyde, of Chicago, Ill.
10. The Curability of Urethral Stricture by Electricity; an Investigation, and
11. The Comparative Value of Supra Pubic and Perineal Drainage in Curable and Incurable Bladder Disease. By Dr. E. L. Keyes, of New York City, N. Y.
12. The *Filaria Sanguinis Hominis* in the United States, especially in its Relationship to Chylocele of the Tunica Vaginalis Testis. By Dr. W. M. Mastin, of Mobile, Ala.
13. A Case of Perineal Section for Tramutic Retention; Unusual Condition of the Bladder. By Dr. J. E. Michael, of Baltimore, Md.
14. The Prophylaxis of Syphilis. By Dr. P. A. Morrow, of New York City, N. Y.
15. Unusual Case of Urethral Calculus. By Dr. H. G. Mudd, of St. Louis, Mo.
16. On the Radical Cure of Stricture by Dilating Urethrotomy, and
17. Demonstration of a Perfected Evacuator, and an improvement in the Method of Removal of Debris from the Bladder. By Dr. F. N. Otis, of New York City, N. Y.
18. Pyæmia as a Direct Sequel of Gonorrhœa. By Dr. R. Park, of Buffalo, N. Y.
19. Retrojections in Gonorrhœa. By Dr. E. R. Palmer, of Louisville Ky.
20. Prostatotomy for Enlarged Prostate at the age of Forty-two. By Dr. Abner Post, of Boston, Mass.
21. A case of Removal of Both Testicles for Recurrent Carcinoma, and,
22. A case of Nephrolithiasis Complicated with Hydronephrosis, in which Lumbar Nephrotomy was Performed. By Dr. F. W. Rockwell, of Brooklyn, N. Y.
23. Some Points on the Differential Diagnosis of Bladder and Kidney affections, with Demonstrations of the Cystoscope and other Instruments, and
24. On the Physiology of the Bladder. By Dr. Alexander W. Stein, of New York City, N. Y.
25. Local Treatment of Chronic Urethral Discharges. By Dr. F. R. Sturgis, of New York City, N. Y.
26. Some Points on the Etiology of Stricture of the Urethra. By Dr. R. W. Taylor, of New York City, N. Y.
27. Operative Treatment of Hypertrophy of the Prostate,
28. Spontaneous Fracture of Stone in the Bladder. By Dr. F. S. Watson, of Boston, Mass.
29. The Relation of the Prostate to Chronic Urethral Discharges, and The Value of the Tolerance of the Iodides as a Diagnostic of Syphilis, and
30. Urethral Structure and Enlarged Prostate in their Relation to Vesical Calculus and Calculus Pyelitis, with Cases. By Dr. J. William White, Philadelphia, Pa.

## BY INVITED GUESTS.

31. The Prognosis of Stricture, based on thirty years' death record of Stricture at the London Hospital and the Practice at St. Peter's Hospital. By Dr. E. Hurry Fenwick, of London, England.
32. The Congenital Anomalies of the External Urethral Orifice. By Dr. C. Kaufmann, Zurich, Switzerland.

R. W. TAYLOR,  
SECRETARY.

JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

JUNE, 1888.

No. 6

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**Original Communications.**

**MICROSCOPICAL STUDIES ON MELANOTIC TUMORS OF THE SKIN.**

BY

LOUIS HEITZMANN, M.D.,  
New York.

With 5 Illustrations.

**H**AVING had opportunity to examine microscopical specimens of five different cases of melanotic tumors of the skin, which presented the properties of malignancy, I intend to describe their characteristics and the conclusions drawn from a close study of them. I have been unable to obtain the clinical histories of all of my cases, but those known to me proved fatal, with one exception, in from a year to a year and a half after the first operation and after an increase in the number of tumors on the skin.

Of my five tumors, one showed the characters of carcinoma alone, two of sarcoma or myeloma alone and two of a combination of sarcoma with carcinoma. I shall first turn to a description of the latter, in which the peculiarities of the melanotic tumors were most marked.

The one of these was extirpated by Dr. R. of this city from the back of a woman of about 40 years; its size was not much over that of half a walnut and its superficial surface was of a

dark blue color. The tumor increased with such enormous rapidity after this operation, that a second extirpation was positively refused by all who saw her, and the woman died in a very short time. Sections through this tumor, made in the usual manner with the microtome after imbedding in celoidin, showed that the original growth was a melanotic carcinoma, which, however, later on changed its character to that of a sarcoma. While, in the upper layers of the tumor the proliferations of the epithelium of the rete mucosum and the nests formed from the epithelia were everywhere well marked, in the lower, therefore, youngest layers of the tumor no epithelial nests were present, but instead of them, spaces filled with medullary corpuscles, the arrangement of which, though irregular, justified the diagnosis of an alveolar sarcoma. The pigmentation was most marked in the superficial layers in contact with the rete, and gradually lost itself towards the deeper layers showing pure sarcomatous structure.

The specimen shows skin with normal papillæ gradually passing over into the tumor, whereby the papillæ become enlarged, especially the epithelial layer of the rete mucosum greatly augmented (see Fig. 1). The first thing noticed is a brown pigmentation of the epithelia in the deepest layers, principally of the connective tissue of the papillary body. While the unchanged rete shows a diffuse brownish coloration similar to that which we usually observe in persons of a dark complexion, a dark brown tint is noticed in the deepest places of the rete, and at the same time the epithelium loses its regular columnar and cuboidal forms in these places, and appears changed to irregular, coarsely granular protoplasmic masses, a goodly number of which present a dark brown color. The nearer we approach to the centre of the tumor, the more conspicuous the augmentation of the rete mucosum becomes, and the more marked the pigmentation of its marginal zone. In the augmented rete we meet with concentrically arranged nests, which are made up of large plates and epithelia with coarsely granular nuclei. In the deeper layers of the rete the disintegration of the epithelium to coarsely granular protoplasmic masses is well marked. The papillary body and the tissue of the cutis show the features of the so-called small cellular infiltration, the more marked, the nearer we approach the centre of the tumor, and in places which exhibit pronounced epithelial proliferation, no fibrous connective tissue at all is to be found, but only such connective tissue which is changed to protoplasma and to globu-

lar, glistening bodies. The amount of pigment of the connective tissue portion is in some places considerable. The pigmentation itself concerns protoplasmic masses, which greatly surpass the elements of the so-called small cellular infiltration in size and always appear coarsely granular, highly refractive dark brown globular masses forming a pigment cluster. Besides these coarsely granular pigment masses we always see diffusely colored, pale protoplasmic masses, and, especially in the elements of the small cellular infiltration, transitions from a pale brown diffuse, to a dark brown, coarsely granular pigmentation.



FIG. 1.—MELANOTIC CARCINOMA. MAG. 100.

*E*—Epidermis. *R*—Rete mucosum. *N*—Concentrically arranged epithelial nest. *C*—Greatly augmented rete mucosum, the epithelia at the boundary layer between it and the cutis breaking up to pigmented medullary tissue.  
*D D*—Cutis with marked inflammatory infiltration.

That this specimen is really a carcinoma, is shown by the nests filled with epithelia, which are seen in the upper half of the tumor (see Fig. 2). Some of these nests resemble the structure of adenoma, there being present occasional, though irregular calibres. The epithelium has a strikingly brown, though diffuse coloration, while dark brown pigment masses can be demonstrated only in the connective tissue and in the nests of medullary corpuscles. In the deeper layers of the tumor no epithelial nests are found, but only, as already specified, alveoli filled with medullary corpuscles, and here we find no coarsely granular

pigment at all, but only a diffuse, brownish discoloration of the medullary corpuscles. The number of blood-vessels throughout this tumor is nowhere especially large.

The most important question in this case appeared to be how the carcinomatous structure originated from the rete, and this question it was not difficult to solve, because the proliferating epithelia of the rete were characterized by their abundance of pigment. The second question, how a sarcoma or myeloma could originate from a carcinoma, can be explained at once by a more abundant growth of the medullary elements, which have



FIG. 2.—MELANOTIC CARCINOMA. MAG. 300.

*NN*—Alveoli filled with epithelia. *C*—Cutis with marked inflammatory infiltration, containing dark brown pigment clusters. *L*—Blood-vessel.

not sufficient time to be changed to epithelia. To this mixture of cancer with sarcoma Virchow<sup>1</sup> has long ago drawn attention, and has proposed for them the name of sarcoma-carcinomatodes. Everyone who has the opportunity to examine a large number of tumors, will admit that such mixed tumors are by no means rare, and clinically almost always show a high degree of malignancy.

Let us now study the margin of the rete in close contact with the papillary body in our case, where there is a commenc-

<sup>1</sup> Die krankhaften Geschwülste, Vol. II, 1864.



ing formation of carcinoma (see Fig. 3). The first thing noticed is a strikingly coarse granulation in the interior of the epithelia, which partly originates from the nucleus, partly goes together with the formation of vacuoles around the nucleus. The formation of vacuoles or plasma spaces is most marked in those places where the transformation of the rete to carcinomatous tissue is

*M*

*L*

FIG. 8.—MELANOTIC CARCINOMA. MAG. 600.

*R*—Epithelia of the rete mucosum. *MM*—Epithelia breaking up to deeply pigmented medullary tissue, well supplied with vacuoles. *I*—Inflammatory infiltration of cutis. *O*—Blood-vessel.

most conspicuous. The epithelia thereby take on a dark brown pigmentation and lose their regular forms, changing to many-nuclear protoplasmic masses, from which medullary corpuscles originate; from the nests of such medullary corpuscles, true epithelial nests are formed. The growth of the rete-epithelia to cancer-epithelia is therefore not a direct one, but is characterized

by the appearance of an intermediate stage of pigmented medullary tissue.

My second case of mixture of sarcoma with carcinoma was taken from a younger person, in whom the disease also rapidly proved fatal. The carcinomatous portion of this case is limited to a marked broadening and lengthening of the rete mucosum in certain places, whereas in other places the rete mucosum is greatly thinned, as is always the case in a sarcoma (see Fig. 4). If we study a specimen of the latter form with lower magnifying powers, we will observe a reduction of the epithelial tissue and at the same time an augmentation of the connective tissue elements, therefore enlargement of the papillary body. Within the rete, pigmentation is found as well in the deeper layers of the rete as in the stratum lucidum and stratum corneum, though in the two latter layers the amount of pigment is quite small. At some places we find quite a large new formation of blood-vessels in the papillary body, so much so as to show the features of an angioma. In the larger mass of the tumor, alveoli with large elements are found, which justify the diagnosis of alveolar sarcoma. Here and there nests of the so-called small-cellular infiltration are also present, and such nests give the features of a small round-celled or lympho-sarcoma. The pigmentation in this case is limited entirely to the rete and the papillary body, while the sarcomatous tissue itself appears unpigmented. This circumstance can be established with certainty with higher magnifying powers (see Fig. 5). The epithelium of the rete is seen in a diffuse brownish color, the nuclei being in some places entirely free from pigment; in others, however, also discolored. Towards the boundary zone we find numerous epithelia with pigmented, coarsely granular protoplasma, here and there surrounded by hyaline plasma spaces. The pigmentation in these places quite frequently originates from the nuclei of the epithelia; in the place of the nucleus a dark brown mass is met with, and occasionally we even find a second dark pigmented nucleus near a slightly changed one in the interior of the epithelium. The granular pigmentation is, as in the first specimen, especially marked in those places in which a disintegration of the epithelia to medullary corpuscles takes place. The cancerous structure is made evident by the presence of concentrically arranged epithelial nests within the rete and an occasionally intense thickening of the rete tissue. It is especially in such hyperplastic formations of the epithelium that the disintegration of the epithelia to pigmented medullary elements is most

pronounced. That the medullary tissue which has originated from the epithelia can directly be changed to sarcomatous tissue, is seen in many places of the tumor, where the thinned rete is directly bounded by the sarcomatous tissue. While the transitional zone appears distinctly pigmented, the pigmentation is much less marked in the sarcomatous tissue; the latter has an alveolar structure and the alveoli are filled with partly pear-shaped, partly globular elements, so that the diagnosis of alveolar-sarcoma can be established.

From the two above described forms of mixed melanotic tumors, the diagnosis of my other three specimens is plain. I had

FIG. 4.—MELANOTIC ALVEOLAR SARCOMA. MAG. 100.

*E*—Epidermis. *L*—Stratum lucidum. *RR*—Rete mucosum. *D*—Cutis in marked so-called small cellular infiltration. *A*—Angioma. *MM*—Non-pigmented alveolar sarcoma.

the good fortune to obtain a specimen of primary pure melanotic carcinoma of the skin. In this specimen the rete pegs are greatly augmented both in length and breadth, even some distance away from the real tumor. In connection with the epithelial cones are found cancer nests, which do not extend far into the derma; the latter is everywhere in a condition of small cellular infiltration. Pigment is found in this case also, both in the stratum lucidum and stratum corneum, in the former in spindle-shaped lumps, which are for the most part present in the nuclei of the epithelia, in the latter in coarse masses apparently in epithelia which have escaped complete transformation into horny substance. In

the rete the pigment is present only in moderate quantity and almost exclusively in the nuclei of the epithelia; whereas both in the connective tissue and the epithelial portions of the carcinoma the pigment clusters are exceedingly numerous and here show a distinctly diffuse brown color.

My two specimens of pure sarcoma give rise to very few remarks. Both belong to the group of alveolar sarcoma with numerous transitions to round-celled sarcoma (Globo-myeloma). In one case the pigmentation is present only in the latter portions of the tumor, while the alveolar portion itself is almost free from pigment. The epithelia of the rete are everywhere reduced, so much so that in some places only a few layers of epithelia are left. The papillæ are greatly broadened and flattened to an almost complete disappearance of the papillary layer, occurrences that are characteristic for the formation of sarcoma.

The question now arises, what is the pigment, and how is it that melanotic tumors, as a general rule, have such a high degree of malignancy, that they return after each extirpation and rapidly multiply both in the skin and internal organs?

The literature on this question has of late become quite large, but the views of the authors are widely divergent. So far two distinct views were held by authors. According to the one, the pathological pigment melanin is a derivate of the hæmoglobin; according to the other the pigment in the sarcoma cells is formed independently of the hæmatin by so-called metabolical activity of the cells from uncolored substances, though the nature of the latter is uncertain. While Langhans, Gussenbauer, Rindfleisch, Vossius and others incline to the former view, viz., that the pigment in the melanotic tumors is, at least occasionally derived from the hæmoglobin, Virchow, Baumgarten, Fuchs and others deny this. Recently two works appeared, with views entirely opposed to each other, the one by Berdez & Nencki,<sup>1</sup> the other by Mörner.<sup>2</sup> Berdez & Nencki's chemical analyses show that there is not the slightest chemical relation between the pigments of the melanotic tumors and the hæmoglobin. Though their analyses were obtained from only one case of sarcoma, they come to the conclusion that the views of the melanotic pigment being derived by means of a transformation of the hæmoglobin, are incorrect and must be dropped. They con-

<sup>1</sup> Ueber die Farbstoffe der melanotischen Sarcome. *Arch. f. exper. Path. & Pharm.* Vol. XX.

<sup>2</sup> Zur Kenntniss von den Farbstoffen der melanotischen Geschwülste. *Zeitschrift für Physiol. Chemie.* Vol. 11.

sider the most probable supposition to be, that the pigment is formed from the albumen by means of a peculiar condensation. While their investigations show that the pigment is entirely free from iron but contains an enormous amount of sulphur, the analyses of Mörner are directly opposed to them, he having found a pretty large quantity of iron in the pigment. On this

*R*

*P*

*M*

FIG. 5.—MELANOTIC ALVEOLAR SARCOMA. MAG. 600.

*R*—Rete mucosum. *P*—Deeply pigmented granular mass, so-called hæmatoblasts. *M*—Alveolar sarcoma, the boundary layer between it and the epithelium changed to pigmented medullary corpuscles.

account Mörner believes that it is a derivate of the hæmoglobin, even though the amount of sulphur of the hæmoglobin is somewhat less and the production of the pigment from it is therefore in all probability pretty complicated. At the conclusion of an elaborate article Dr. O. Oppenheimer<sup>1</sup> says: Are we now

<sup>1</sup> Beitrag zur Lehre der Pigment-bildung in melanotischen Geschwülsten. *Virchow's Archiv*, Vol. CVI.

obliged to assume that there are two kinds of melanotic pigments? So far the anatomists did not favor such an opinion; some believed all pigments to be a derivate of the hæmoglobin, and were supported in this belief by the results of the older analyses. Others pointed to the fact that this opinion was not sufficient to explain all cases and that it was necessary to suppose an independent formation of pigment by means of a cell activity, which however they did not explain any further, and they entirely ignored all facts stated by the other side.

My specimens show that the pigment is of two kinds: first, diffuse or finely granular, from a light brown to a deep black color; and second, of a rust-brown color and coarsely granular form. Both varieties are held by the protoplasma, the diffuse pigment principally in the epithelia of the skin, evidently suspended in the protoplasma fluid. Even in the normal state, the epithelia have, especially in dark-colored persons, a distinct, diffuse coloration. It is the same pigment which gives the hue to brown and black hairs, and which also produces the coloring in the lengthened papillae filiformes in so-called "Black tongue," as I had recently occasion to satisfy myself. This diffuse pigment also colors the epithelia of the choroid coat of the eye, the stroma of the iris, etc. Chemical analyses have shown that this pigment contains no iron, but a considerable amount of sulphur. There are dark pigmentations of the skin, so-called melanosis or melanoderma or melanotic nævus, which can remain for years without any special changes. In these forms we have a diffuse pigmentation and a finely granular deposition in both the epithelia and the cutis. If conditions of irritation arise in such pigmented places, the living matter of the protoplasma becomes augmented, first in the form of glistening, homogeneous globules and granules, which, even in non-pigmented places have a distinctly yellow color, similar to that of the red blood corpuscles, and as such probably contain iron. These globular masses have been designated hæmatoblasts. C. Heitzmann<sup>1</sup> has already several years ago announced the fact, that from these hæmatoblasts, before their development into red blood corpuscles, the pigment clusters arise. From them, however, red blood corpuscles must not of necessity originate, for protoplasma bodies containing nuclei, *i. e.*, medullary corpuscles, may result, which are known either as inflammatory corpuscles or as elements of the tumor according to whether the process attains a typical end by inflammation, or shows an un-

<sup>1</sup> Microscopical Morphology of the Animal Body. New York, 1888.

limited growth by the formation of a tumor with a continuous increase of all the elements. The presence of hæmoglobin in the hæmatoblasts can be easily demonstrated, and it is without doubt the product of a lively process of oxidation. This hæmoglobin contains iron, and the analyses of Mörner have shown that the pigment of the melanotic sarcomas really does contain iron. If now processes of proliferation result in places in which pigment containing sulphur is already present, the hæmatoblasts will easily become the carrier of the pigment, whose chemical nature is an iron-sulphur combination. In all the forms of melanotic tumors, the deep brown pigmentation is most conspicuous in those places where processes of proliferation take place. This relation is most marked in the nuclei of the epithelia. In Fig. 3, the nuclei of the unchanged rete epithelia are almost colorless, whereas in Fig. 5 we notice numerous nuclei, which are coarsely granular and distinctly pigmented besides, while the unchanged nuclei themselves only show a diffuse brown stain. In both cases, the pigmentation is most marked in those medullary elements, which have arisen from a proliferation of the protoplasma of the epithelia.

Pigment then, is, like fat, a product of the living matter. The pigment granules within the protoplasma corpuscles have often been seen in direct communication with the non-pigmented portion of the living matter by means of thread-like processes. The greater the change of matter, the more substances resembling hæmaglobin are formed and the greater the number of hæmatoblasts, so much the more intense the pigmentation appears. It was already known to Virchow, that the pigment is originally bound to the cells and can only be demonstrated after the disintegration of the cells in the form of granular masses or lumps. While earlier observers have frequently expressed the opinion that the pigment is a direct derivate of the blood, supposing hemorrhages to be the foundation of the pigmentation, my researches have proven that blood extravasates are not the cause of the melanotic pigments, but that it is the hæmoglobin alone, which, containing iron, appears every time when more intense local processes of oxidation take place, as is the case both in inflammation and in the formation of tumors. The pigment itself being an intense chemical irritant, its presence causes an active increase of tissue, constituting a tumor, though the secondary tumors need not of necessity contain pigment. In my above-described forms of mixed sarcoma and cancer, the most intense formation of pigment is found in the first formed,

that is, oldest portions of the tumor, while the later growths of a sarcomatous character contain little or no pigment.

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#### A CLASSIFICATION OF BUBOES AND THEIR RESPECTIVE TREATMENT.

BY

EVERETT M. CULVER, A.M., M.D.

Assistant Surgeon to Out-Patient Department New York Hospital, etc.

IN looking over some old volumes of the *English Lancet* a few months ago, I accidentally observed a contribution of reports, compiled from six or seven of the great London Hospitals, upon the subject of the treatment of bubo. The article referred to, was compiled by Mr. Mason, then Surgeon to the Dispensary of the Middlesex Hospital, and is entitled "The Treatment of Bubo in the London Hospitals, by Messrs. Mason, Durham, Callender and Berkeley Hill." (*Lancet*, 1867, pp. 641.) While the order of associating the several methods of treatment in different hospitals is by no means a new one; the advantage it presents is certainly very beneficial, either as information in a compiled and condensed form, or, for the purpose of statistics. After reading the above, the thought suggested itself why not collect some statistics from the hospitals of New York. The subject chosen is not a rare one, but its discussion is well worthy the attention of every man who sees such cases in his practice. Dispensary Surgeons especially need not tax their memories too severely to recall large numbers of these cases every year.

Starting out with the idea of making inquiries, as already mentioned, I find that neither the subject or its divisions seemed to be of much thought.

When I ask "What do you do for bubo?" I almost invariably get the laughing answer, "Do a laparotomy on them," or, "scrape them out." To me, however, the subject is one of very great interest, for the great incision (generally thought necessary) in most cases thoroughly healing a bubo on a careless young man, may seem at the time, a slight operation to undergo; to be almost immediately rid of the pain of so disagreeable a corpuscle to one's anatomy; but when the former patient marries, the presence of an ugly scar in one or both groins, may lead to irritating questions and explanations of the "why and wherefore," and I doubt if the inflictor of such a sign wound would ever be called in for future surgical work.



In general we shall say that bubo is ushered in by some premonitory symptoms, before even slight enlargement is noticed in the groin. Constipation, loss of appetite, nausea and insomnia, then with the appearance of slight swelling come dull dragging pains in the groin and back, especially experienced when walking.

When the surgeon sees the patients' white, haggard faces, depicting so surely their tale of suffering, he is, no doubt, often tempted through pity to take the shortest route to relief, by thoroughly incising the tumor, but thereby leaving a scar.

I remember oftentimes witnessing the most disgusting sights in the wards of German hospitals, when the patient was carried stripped to the invariable little platform in the middle of the ward, laid back in a chair, presenting a swelling in his groin as large as a fist, red, sodden and fluctuating. A clumsy scalpel in the hands of a clumsy student made an incision three or four inches long, and curved scissors cut away the undermined edges over a surface as large as the palm of a good sized hand. After the patient has fainted, a few cupfuls of cold water thrown over his chest and face; a vigorous slap on the chest, "So, mein braver Kerl," calls out the Herr Professor, and the deed is done, but the scar? Well! that remains always.

The literature upon this subject is as voluminous as upon most other surgical subjects and I doubt not that references could be made to two or three hundred articles; but we must remember that all articles upon this matter as upon nearly all others both medical and surgical, to be reliable, should not antedate ten or fifteen years, since pathology lately has aided so greatly to the accomplishments of our modern miracles.

I shall not attempt to treat of the subject in its entirety, but merely wish to suggest special lines of treatment and to advocate a new principle for the handling of virulent bubo. The pathology of lymphatic glands may be said in a few words, the more concise and clearer the better. We *must have* the picture of the disease in our minds before we shall be in a position to understand what I wish positively to emphasize. In order to do this let us take up our material in logical order and consider a normal lymphatic gland.

The compound or true lymphatic glands are directly interpolated in the course of lymphatic vessels. Different vessels enter the gland at one side into the outer capsule, and emerge from it as a plexus of efferent lymphatic tubes at the hilum. Each true gland is enveloped in a fibrous capsule which is connected with

the interior and the hilum by connective tissue trabeculæ and septa. The trabeculæ having advanced a certain distance into the gland about  $\frac{1}{4}$  or  $\frac{1}{2}$  of its diameter in a more or less radiating manner toward the centre, branch into minor trabeculæ which in the middle part of the gland anastomose with one another so as to form a plexus with small meshes. Thus the peripheral third or fourth is subdivided by the trabeculæ and septa into relatively large compartments, while the middle portion is made up of smaller cylindrical or irregularly shaped compartments. The former is the cortex, the latter the medulla of the gland. The compartments of the cortex anastomose with one another and with those of the medulla, and the latter also with one another, forming one inter-communicating system. The capsula, trabeculæ and septa are fibrous connective tissue and are the carriers of vascular trunks. The compartments contain masses of adenoid tissue without being completely filled. Those of the cortex containing oval or spherical masses the "lymph follicles" of the cortex; those of the medulla, cylindrical or irregularly shaped bodies, the "medullary cylinders." The cylinders and follicles are composed of adenoid tissue and this tissue contains the last ramifications of the blood-vessels which enter and leave the gland upon the connective tissue framework. The cortical follicles and medullary cylinders do not completely fill out the compartments in which they lie, but a small space at the periphery is left free. These are the lymphatic sinuses and these spaces, roughly speaking, are covered with a continuous layer of endothelium and are traversed by a coarse reticulum of fibres.

The course of the lymph is as follows :—

When the afferent vessels carry the stream into the capsule, its plexuses distribute its contents through the gland. Owing to the reticulum in the sinuses the current of lymph will proceed only very slowly, and with difficulty, as if it were passed through a sponge. Hence, a large number of formed corpuscles, pigment, inflammatory or other elements are easily arrested and deposited in the sinuses, and there readily absorbed into the corpuscles lying in the meshes, while the more fluid and obnoxious particles flow outward and are carried on to the efferent vessels.

If now, having been faithful to my object to secure to your minds the word picture, we shall have no trouble to appreciate the course of inflammatory material which excites morbid action in gland tissues. This process of the absorbing and the storing up of these products will give us a clear insight

(in so far as we now know) how these changes take place, how we can recognize them, and best treat them. It is necessary, therefore, to seek for each and every circumstance connected with the history, a correct pathological knowledge of the causes, and a determination to know, if possible, by examination of the patient, the real nature of each individual case.

We shall commence with a type of glandular swelling such as occurs in acute cases of clap. As a rule the glands along the upper inguinal lymphatic chain are swollen, one or two more than others; they are tender and enlarged. Pus has been carried from the penis along the lymph channels and sifted into the tender in-

A NORMAL LYMPHATIC GLAND.

a—Capsula. b—Cortical lymph follicles. c—Medullary portion.  
d—Lymph spaces.

guinal glands; here it is stowed up to await future changes. The pus has been absorbed by the cells in the sinuses and is safe for the present, the patient need have no fear of a bubo as yet. Most surgeons will agree that this variety rarely suppurates. In these cases the patient needs but a few days of rest, preferably in a recumbent position, with an ice-bladder or cold towels laid over the groin, with lighter cases, a little tr. iodine around (not over) the gland, or a touch of the Paquelin Cautey around the enlarged gland, and over the course of the afferent vessels, and he is well. But observe, his clap having been cured, he has no more enlargement or tenderness of the glands, but his

trouble is not yet ended. He may go months or years with not a thought of danger, and having led a perfectly pure life, when suddenly from some urethral irritation, a new clap or urethritis, a sudden strain, from lifting, walking, running, playing tennis, bowling and the like, the inguinal glands begin to swell, grow painful, and with all the symptoms of ill health that accompany it. What has happened? Let us see what particular process has been at work in that gland. For the double purposes of clearness and order, it will be necessary to make a digression—a few words of explanation.

The lymphatic glands in the inguinal region are composed of two sets, the upper and larger set leading from the genitalia and surrounding region, and the apex or lower, turning over the cribriform fascia and saphenous opening receiving the lymph from the lower extremities. It is a well-known fact that abrasions and ulcers of the leg and foot often enlarge the glands of the groin, and that a suppurating corn or bunion often cause suppurating bubo. These lower chains of glands are in a manner intercommunicating with the upper chain and it may happen, that in a state of severe irritation, that they may and do, through continuity, indirectly cause suppuration of the upper chain also, so that in looking for the cause of the so-called idiopathic bubo, we should not forget this fact. If exception be taken to the phrase, "so-called idiopathic bubo," I shall hasten to explain. No man is so foolish nor so skeptical even in these very doubting days, as to refuse to believe without exception what he cannot see; but no case of bubo has as yet been presented to me that a cause was not found or inferred. Some of our text-books tell us, that strain, ill health, etc., are the cause in some cases, but in spite of all that there has been somewhere and sometime a starting point of infection. Köenig says that even a very slight abrasion of the penis caused by friction in the act of coition, slight cases of urethritis not noticed perhaps or forgotten by the patient until carefully questioned, small chancroids that heal kindly, are more likely to lay the foundation for future bubo, than a more virulent and far more extensive inflammation attendant upon clap. Having noticed these minor causes we may now resume an explanation of latent bubo. If I may be permitted the expression, as before said, the inguinal glands rarely suppurate *during* a case of acute gonorrhœa, but rather at remote periods, varying from six months to a number of years (Ricord relates a case after three years; I have seen one lately after twelve years). This may be ac-

counted for in two ways, and also supplies us with the hypothesis for, and the diagnosis of, two separate forms of simple bubo, viz.: the simple suppurating glandular variety, and the periglandular or periadenitic form. Having already in mind the histological structure of these glands, pathology demonstrates the true action of the morbid process. When pus enters the lymph stream it is carried to the nearest gland and is there strained out into the meshes of the reticulum. One of three actions is now set up in the gland tissue.

First, either the pus may be but slightly irritating to the parenchyma of the gland, the pus cells being absorbed into the glandular elements of the lymphoid corpuscles, undergo fatty degeneration and are absorbed into the general circulation, exactly as in many other cases of resolution by fatty degeneration; or second, the pus may cause irritation, the blood-vessels of the capsule become enlarged, these necessarily causing a secondary engorgement of the small vessels following the connective tissue trabeculae within the parenchyma. This increased vascularity necessarily causes an hypertrophy of the connective tissue stroma, diminishing the lymph sinuses and adenoid spaces and compressing the capsule; these freshly made wall-divisions then shrink, narrowing the nutrient arteries to such an extent that the lymphoid corpuscles become necrosed, setting up numerous pus foci through the gland. These gradually coalesce running into larger foci, communicate the inflammation to the capsule, which in turn lends the element of irritation necessary to cause suppuration of the surrounding connective and adipose tissue already encroached upon by the now thickened capsule and enlarged gland.

Third, a simpler process may be theoretically advanced to account for the simpler suppurating cases, that is, the irritation from pus may violently enlarge the vascular supply to the lymphoid particles, the gland having already undergone a process of hypertrophy, so that the small arteries are torn away, or ruptured by the engorgement, thus causing molecular death from want of nourishment. Pathology has explained why a length of time is necessary to accomplish this rather elaborate process.

We have then for divisions; first, non-suppurating bubo, occurring with an acute attack of gonorrhœa; second, the periadenic bubo, involving large areas of tissue and generally the gland itself; and lastly the simple suppurating bubo attacking only the glandular structure. We may now rationally discuss the treatment. The simple glandular enlargements coming on with

acute clap need (as before mentioned) only a few days rest in a recumbent position, with the leg elevated and the thigh slightly flexed to the degree of comfort, a bladder of ice laid over a towel to protect the skin, a mild cathartic and some alkaline mixture, generally succeed in dispersing them entirely in a few days; or the further counter irritation as before mentioned.

For the treatment of the second and third varieties a correct diagnosis is of great service to determine if possible the distinction between adenitis and peri-adenitis. In comparatively thin subjects, this is not difficult, Bubonocoele having been



CHRONIC CONDITION IN LYMPHATIC GLAND BEFORE GENERAL SUPPURATION.

a—Adipose tissue. b—Capsule. c—Foci of suppuration. d—Connective tissue, new formation compressing adenoid tissue.

excluded, the points of differential diagnosis are these. In adenitis the gland is at first broader, very distinct in outline, can be mapped out pretty well, does not as a rule fluctuate (the capsule at this time preventing any wave movements), the tissue surrounding the gland is hard, not doughy, not very cedematous and but little reddened, also but little pain upon pressure. If we question our notes for numerous successes in aborting these cases and find but few, we shall be satisfied with ourselves when we remember that three quarters of our dispensary patients do not present themselves for treatment until very late in the disease. Could we as surgeons but see these cases at

beginning, we should be able to abort the majority of them. When the patient is seen early, we should by all means strive to abort and disperse these swellings. After several years' experience with many cases each year, I am inclined to discard the thousand and one remedies suggested for the treatment of bubo, and resort simply to the following: A brisk cathartic, followed by a good tonic and a medicine that has acted nearly as a specific in most glandular enlargements, this is the chloride of calcium. As suggested by Dr. C. H. Wilkin, we now use the above at the Out Patient Department of the New York Hospital Class in Surgery, in doses varying from 5 to 15 grains thrice daily, or every four hours. This drug acts almost marvelously upon glandular swellings of various origin. Of its therapeutical action little is known; for local application I am accustomed to use either green soap, rubbing a piece about as big as a good sized chestnut gently over the swelling, night and morning, or a solution of iodine pur. 3 i to an ounce of collodion, painted freely over and around the parts, taking care to have one half of the pubes well shaved. For this latter procedure I am indebted to Dr. Bulkley, who long ago informed me that he had used this application for a number of years with much success. Burning or blistering the surface I consider as radically wrong. My experience with injections of ætherial iodoform, weak and strong solutions of Churchill's Tr. iodine (on account of its solubility), solutions of the bichloride of mercury 1-1,000 and 1-2,000 and varying solutions of carbolic acid, exactly correspond with Dr. R. W. Taylor's results, who graphically described them to me as "lurid failures." Drs. Podec and Gwernosky, division surgeons of the Austro-Hungarian army, have jointly written a long and interesting account in an article entitled "Zur behandlung der Bubonen" (*Weiner Med. Wochenschrift*, 1882. XXXII., pp. 1,070). In this they detail the experiments made upon a large number of soldiers suffering from bubo from various causes. They sum their results as follows: "After trying these injections upon a large number of bubos of various origin our own experience is that such injections only hasten them toward suppuration." As a means of abortion the compressed sponge has been often tried by us, but where one success was obtained, twenty-five failures have occurred. If the patient is unable to take rest, the sponges may sometimes resolve the bubo by heat and moisture, as many cases of cellulitis are dispersed by poultices, and in this way effect a cure, but the mere compression acts, I think, rather as an irritant than otherwise.

We may thus summarize our treatment for this division, medication—active if possible, external application of green soap or the iodine collodion. If, however, these do not succeed and the swelling steadily becomes larger and softer, or should we have seen our patient late in the disease, we should poultice assiduously to hasten suppuration and break down the involved tissue as much as is possible. The cavity is then to be opened by a vertical slit which leaves less of a scar, heals kindlier and does not gape so dreadfully, as the incisions made in the long axis. Or better still, we may aspirate the sac, wash out the cavity with an antiseptic, spray it full of ætherial iodoform, and keep the wound patent with a bit of gauze, dress antiseptically with a compress and so attain a cure without the trouble of many dressings, and without a scar.

Thirdly, the periadenitic variety, which is known by the following signs: The gland is not easily outlined, area of swelling is greater, more doughy, pits on pressure, sometimes distinct fluctuation upon palpation. If early recognized you will save time by poulticing it directly and at the same time giving the chloride of calcium, with the hope of attaining early and thorough suppuration. The gland itself is the centre of irritation, and you can never save it, even if you have opened the abscess cavity and evacuated pus, the gland still remains as a hard, grizzly mass, a source of further irritation, and prevents the wound healing. It is better, therefore, to thoroughly suppurate the whole cavity, then aspirate and proceed as before with washing out and dressing, or if the gland will not suppurate, cut down upon it and either dissect or scrape it out. In these cases many experiments have convinced us that nothing causes these cavities to fill up so quickly and kindly as to spray them out thoroughly with the ætherial iodoform, and pack with small pledgets of gauze.

We may next consider in order the chancroidal bubo. The question is often asked, "Can they ever be aborted?" From my own observations I should say *never*. One must bear in mind from what has been said, that if bubo can be dormant or latent for a long period of years, that coincidently they may occur at the time of a chancroid, from the ill health that generally attends upon these cases, and that it is not at all necessary that the chancroidal virus has entered the glands. But when we get a history of chancroids with rapid and diffuse swelling in the inguinal glands of the upper chain, and a negative history of clap, etc., we should give the patient no hope that his trouble



will be aborted. That we know chancroidal pus to be one of the most virulent of poisons, is too well acknowledged to admit of even the most trifling denial. Once inoculated into gland, skin or tissue, whether upon the patient himself or upon another, the characteristic ulcer is formed and the process may be repeated by successive inoculation almost indefinitely. Thus the entrance of the specific pus into the gland substance or capsule is sufficient to produce from one or two infecting corpuscles the death of the whole gland. So soon as we are satisfied that the attack is really chancroidal, we shall recognize certain stages in the treatment. The capsule of the gland for the time that it remains intact saves the surrounding tissues from infection, but when this envelope bursts and the highly infectious pus comes into contact with the surrounding tissues, the same form of tissue-necrosis goes on as in the gland proper. Every structure is destroyed—vessels, nerves and fascia—and the condition of phagedena comes on; so well known for its fearful ravages. These abscesses of course often burst spontaneously and become huge specific ulcers capable of further transmitting the poison; the edges are undermined to a great degree and the process of repair, unaided by surgery, is tedious and exhausting. The resulting cicatrix is usually most disfiguring, painful, and often the source of irritation for years. The method I wish especially to advocate for the treatment of these cases is that of aspiration and irrigation. Heal as rapidly as possible the primary sores upon the genitalia. Hasten suppuration by warm poultices, give the patient a good tonic, generous living, with stimulants, clean out the bowels which are generally constipated, and prescribe opium to relieve pain and promote sleep, as it seems also to have a local effect upon the disease. At the first evidence of pus, aspirate the sac or allow the pus to drain away, then irrigate the cavity of the abscess with the 1-1000 solution of mercuric bichloride, thoroughly distending the cavity which is to be done at least once every day, lay over the abscess wall a piece of lint with Ung. Zinici Oxidi, a small compress of absorbent gauze and retain in place with a spica. If this method is correct we have accomplished the following changes: we have converted a specific abscess into a non-specific ulcer, the cavity walls are now in a state ready to heal by adhesive inflammation, and in a few days will heal kindly without further suppuration or tissue necrosis, the scar will be no larger than a dime piece, and your patient is cured without the pain of an operation and the distressing

washings and packings heretofore employed. This method has been well tested, and received the additional support from the following deductions. The idea of aspiration is not new. Ten years ago Koenig advocated this method for abscess cavities, and since that date has been many times noted. Sturges advises it in his little book entitled "Students' Manual of Venereal Diseases," N. Y., 1881. Aspiration leaves but a minute scar, and when the canula is of sufficient calibre, is the best means of forcibly dilating the abscess cavity. For the method of aspiration I claim no credit further than its application to the suppurating simple bubo, and to the chancroidal bubo; the washing of the abscess cavity with an antiseptic, thereby converting the specific into a non-specific cavity and the prevention of an ugly scar, I claim as novel and heretofore not recorded. That the cases experimented upon have not been simple bubo, filled with laudable pus, I have been assured, since a number of cases have been auto-inoculated with the pus withdrawn in the first evacuation, and have fully taken as chancroidal ulcers, capable of furnishing further inoculable pus; while that taken after the washing has given a negative result. One class yet remains and that is the tuberculosis bubo.

Opinion upon this class seems to be divided amongst the surgeons, whom I have questioned. That the tuberculous process *may begin* in the inguinal glands there is no doubt, but whether it really does do so is as yet undecided. The following case will serve as an experience of the uncertainty of clinical history in this class of diseases. J. W. æt 32, tall well made man of 5.11½, weight about 168 pounds, stoker. Family history good. Never remembers to have had gonorrhœa since twelve years ago. Had large tumor in right groin, size of large hen's egg; not painful nor red. Physical examination shows both apices to be consolidated, small moist rales over both sides. Slight hectic flush; says he has night sweats, and that his cough and sweats came on after the swelling had appeared in the groin. These symptoms would seemingly all point to the inguinal adenitis as the origin of affection. The gland was removed at once. It measured 6.25 centimetres through the major axis, by 4.75 centimetres through the minor axis. Microscopic examination showed it to be merely a chronic hyperplasia of the connective tissue, enlarged vessels, with an enormous number of young cells. The inference was of course not sustained.

In conclusion I must thank Dr. R. W. Taylor for his courtesy

to me; also to Dr. C. H. Wilkin to whom I am indebted for much kindness in being allowed to have charge of all these cases coming to his class and also to his valuable suggestions on operations and treatment.

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## Society Transactions.

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### THE NEW YORK DERMATOLOGICAL SOCIETY.

#### THE 181ST REGULAR MEETING.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. KLOTZ presented a

#### CASE FOR DIAGNOSIS.

Otto P—, et 4, was brought to the German Dispensary on April 10, 1888. He is apparently a strong, healthy child. The mother is healthy. She had one child by her first marriage. It was born about 18 years ago and died of diphtheria. By her second husband she has had one child, now six years of age, a miscarriage previous to the birth of the child present to-night and a miscarriage since then.

The child had diphtheria a few months ago since which time there has been a running from the nose and the entrance to the nares, and the upper lip has been sore. The present eruption appeared about six weeks ago. There is a patch on the right knee, which is rough, hard, horny and showing numerous papules. This, which probably resulted from kneeling and creeping around, is, however, only an exaggerated condition frequently met with in children.

Both palms and soles are affected in a peculiar manner. Upon both of these a nearly uniform horny accumulation is found which is traversed by more or less shallow fissures and cracks. On this surface are thin crusts and scales but no evidences of ulceration. On the soles a distinctly marked and elevated red border separates the patch of infiltrated skin from the healthy portions. On the palms this margin is not so distinctly visible. The affection is not accompanied by either itching or by pain.

In the discussion Dr. Bronson thought that the case was a very pretty example of ichthyosis follicularis on the limbs and of keratosis palmaris and plantaris.

DR. BULKLEY said that he would not regard the palmar and plantar changes ichthyosis, but he considered it to be a dermatitis affecting a peculiar region. He had seen many such cases but not in one so young. The sharp margin suggested an erythema marginatum. He had observed that it was accompanied by heat and pain. Sometimes there was exfoliation of the epidermis, sometimes not. There was nothing known in regard to the causation of the affection nor of its treatment. He would call the case one of dermatitis palmaris et plantaris.

DR. FOX agreed with Dr. Bulkley that the affection was not ichthyosis.

This latter did not appear in so circumscribed a manner. He thought that the inflammation was primary and the exfoliation was secondary. The extension of the disease and the margin suggested somewhat syphilis in his opinion. If it was not specific in its nature, salicylic acid in oleum ricini externally would do good.

DR. SHERWELL stated that he could see no relationship between the affection on the knees and that on the palms and soles. The former was ichthyosis, the latter seemed to him to be dermatitis.

DR. ELLIOT said that he could not see any reason for regarding the changes on the palms and soles as specific. They seemed to him to represent that form of dermatitis mentioned by Dr. Bulkley. The patches on the knees were clearly ichthyosis follicularis which affection also existed to a lesser degree upon the extensor surfaces of the extremities.

DR. KLOTZ, in summing up, stated that the patient had been under specific treatment and had improved. The rapid development of the disease was, he thought, against both ichthyosis and keratosis. There was no history pointing to specific disease, but still the so-called diphtheria may possibly have been the primary lesion. It must be said that the treatment justified a diagnosis of syphilis.

DR. BRONSON presented a

#### CASE FOR DIAGNOSIS.

The patient was a man 58 years of age. He had been first seen by Dr. Bronson about one year before and not again till recently. At the time of the first visit his ailment consisted of a circumscribed affection of the skin of the nose. The surface was elevated, somewhat tubercular, with two salient nodules, one on the left ala, the other to the right of the middle portion. The color of the affected patch was of a dusky red or purplish hue, and there was considerable dilatation of the blood-vessels. The epidermis appeared to be unaffected. At that time no positive opinion was expressed regarding the nature of the disease. It was thought possible, from the appearance presented, that it might be a peculiar form of hypertrophic rosacea. About a year previously a growth on the right side of the nose had been excised at Mount Sinai Hospital, and a considerable cicatrix remained at the site of the operation. The surface was scarified two or three times by Dr. Bronson, and then the patient disappeared.

On his return, recently, no material change was discovered in the growths upon the nose, excepting that the nodules were larger and had become granular or warty on the surface. A similar lesion had also appeared in the mustache below the left nostril. The general surface of the patch was of a livid color, the epidermis remaining unaffected. The entire left ear had also become affected with what seemed to be a similar growth, was much thickened, tubercular and nodulated, of a dark purplish or livid color and very vascular. The epidermis was unchanged. The right ear was, to a limited extent, similarly affected. On both feet and hands there are similar growths. These are flat, smooth, irregularly tuberculated and of various shapes and sizes. There were several patches also on the legs and on the buttocks, and some deep-seated nodules could be felt in the skin of the forearms. Most of the growths were of a dusky or livid color, those on the feet and legs being more deeply pigmented. The soles of the feet were markedly affected, and in several places the deeper-seated growths were attended with very severe pain. The pain seemed to be of an intense aching character and kept

the patient much awake at night. The general health did not appear to have suffered much. A history of syphilis was wanting. The diagnosis of multiple pigmentary sarcoma has been ventured with some misgivings.

DR. BULKLEY thought that it was a very curious case. He would consider it one of melano-sarcoma. It would be difficult to say whether it started from the corn on the foot or from somewhere else. He would expect to find a more general distribution than on the extremities alone.

DR. FOX said that it was difficult to make a positive diagnosis by gas-light. Some of the patches resembled melano-sarcoma, but others were quite light in color. He thought it might get well under treatment. He had frequently seen diffuse gummatous infiltration of the nose resembling those on the nose of this patient, and this case might be one of syphilis, still he would not make a certain diagnosis.

DR. LEWIS thought it was a melano-sarcoma. The diagnosis of lesions on the nose lay between syphilis and that disease, but he saw nothing which was in favor of the specific disease.

DR. KLOTZ was of the opinion that the generalization of the disease, spoke in favor of a pigmentary new growth.

DR. ALLEN thought the case was one of melano-sarcoma, though the lesions on the nose looked very much like syphilis.

DR. SHERWELL was of the same opinion, but thought the lesions on the nose complicated the diagnosis. It was his impression that the hands and feet were especially the seat of melano-sarcomata. He had seen a number of such cases, in one of which the primary lesions had begun in the subcutaneous connective tissue, and were pale and red at first, but they became subsequently dark in color. He would not lay much stress on the color. He had removed, eight years ago, a melano-sarcoma of the forehead, which had developed in the scar of wound from a stone, and there had not been any return. He considered the foot in Dr. Bronson's case very typical of the disease.

DR. ELLIOT stated that he regarded the case as one not of melano-sarcoma, but of pigmentary sarcoma. He would regard the case as one corresponding to those described by Kaposi as multiple pigmentary sarcoma of the skin. The history of the case as given by Dr. Bronson, the generalization and situation of the new growths, especially upon the extremities, and the color were in favor of that view. As far as melano-sarcoma was concerned, it was a most malignant new growth, which was characterized by the presence of a peculiar coloring matter. This pigment consisted of small granules, which were contained in the cells themselves, and were found outside only when some cell had undergone degeneration and death. This melanin was still of undecided origin. It was a question whether it was derived from the blood or not. Some observers had found traces of iron on examination, others had not, and it is still necessary to look upon melanin as of unknown or at least of uncertain origin. Its malignancy was well shown when a melano-sarcoma was subjected to irritation or to operative interference, since under such conditions rapid generalization and death of the patient has ensued. On the other hand, the pigmentary sarcoma did not seem to be influenced by such means and in fact to be curable. In this class of sarcoma the pigment was not melanin, but derived directly from the blood. Its presence could be traced to slight hemorrhages due to rupture of the thin-walled blood-vessels, and it was easily distinguished from the melanin, since it was situated between the cells and not in the cells. Dr. Elliot thought that it would be very advisable to try Dr. Köbner's treatment—the hypodermatic use of arsenic—in this case. Possibly a cure might be obtained in that way.

DR. BRONSON, in summing up, said that he had listened with interest to Dr. Elliot's remarks, since they agreed with the view he held, that the case was one of pigmentary sarcoma. When he had first seen the case, he did not think it was sarcoma or syphilis. He had excluded syphilis on account of the history, and the course of the lesions. There was neither ulceration nor cicatrices, nor evidence anywhere on the body of recent or old syphilis. He had thought, about a year ago, that the lesions on nose might be due to a peculiar form of rhinophyma. But when he had seen the case this time, the generalization gave the idea that the disease was a new growth, and he had diagnosed sarcomatosis cutis. He would also call attention to the extreme pain complained of by the patient, which would suggest that nerve trunks were involved in the process.

DR. ALLEN asked if Dr. Bronson had noticed the scar on the side of the nose.

DR. BRONSON said, he had, but it was on the site of the growth that had been removed at the Mount Sinai Hospital.

DR. SHERWELL asked if melanin and indican were the same. He remembered a case he had had of melanotic sarcoma, in which the urine was of a dark blue color.

DR. ELLIOT said that there was no relationship between indican and melanin. In color the one was bluer the other was black or dark brown. Black urine could and did occur in advanced cases of melanotic disease, and melanin was present at such times. Indican could also be present in great quantities in the last stages of sarcomatous affection, but he had never heard of the urine becoming decidedly blue from its presence.

DR. SHERWELL asked Dr. Bulkley if he remembered a man who had a number of pedunculated tumors which were pigmented. He mentioned it because he removed some by ligature and the others flattened down and disappeared leaving cicatrices.

DR. CUTLER asked if the tumors were darker in color when melanin was present, than when ordinary pigment.

DR. ELLIOT said that as a rule the true melanotic tumors were the darkest. Melanin was usually of a deep black color, whereas, the pigment derived from the blood was brown.

DR. R. M. FULLER presented a case of

#### DISEASE OF THE NAILS.

The patient, a night-watchman, married, and 50 years of age, was born in Holland. He presented himself for the treatment of the affection of the nails, his general health being very good. The nails were found to be normal in color, their surfaces polished and glistening as usual, except the longitudinal central portions which were affected to the free outer extremities. The diseased portions had transverse fissures varying in length, in outlines, and presenting the so-called worm-eaten condition. There was no pigmentation or discoloration. On and beyond the lunula were ridges extending across the nails. The free extremities were quite regular. No portion of the root or matrix was inflamed, and there was no active general inflammation around on the skin.

The patient acknowledged having had venereal diseases, but not syphilis. He denied having had any general eruptions on the skin or of having followed any prolonged course of treatment. He says he has the habit, contracted 20 years ago, of scraping the nails, and of removing the surplus skin from the posterior portions, and attributes the present trouble to this habit.

DR. BRONSON in discussing the case said that he thought the symptoms present were common to a number of diseases of the nails. He could see nothing pointing to syphilis, but thought the affection was most probably produced by an eczema.

DR. BULKLEY ascribed it to an eczema of the matrix of the nail. The patient's continually picking at it, caused sufficient irritation. He would mention in this connection the case of a child seen by him, who had been stung by a bee about a quarter of an inch below the matrix. A permanent disturbance in the formation of the nail resulted from this. He thought the present case could be cured by treatment. He would recommend hot and cold water alternately three times a week and diachylon ointment.

DR. FOX agreed with Dr. Bulkley, and thought that a distinction should be made between faulty nutrition and disease of the nails. In this case he would consider eczema as the cause of the changes.

DR. ALLEN was inclined to think that syphilis had something to do with the disease in Dr. Fuller's case.

DR. FULLER said that there was nothing in the patient's history or on his body indicative of syphilis. He owned to having had gonorrhœa, but nothing else.

DR. SHERWELL said that from the history the man gave him he thought that he had had syphilis. In a case he had had in which similar symptoms were present, he had found that it was due to the man's continually dipping his fingers in beer.

DR. TAYLOR thought that the point taken by Dr. Bulkley and Dr. Fox was a very good one. The atrophy and destruction were due to inflammatory changes around nail, and this was greater as the base or semilunar sulcus was affected. He instanced his own case. A short time before he had wounded the matrix slightly, just behind the lunula and now there was a distinctly seen and evident zone of atrophy extending across the base of the nail.

DR. BULKLEY said that he had noticed the same thing produced by pushing back the flesh at the semilunar sulcus as was done by manicures.

DR. FOX asked whether undoubted syphilitic onychia had ever been seen affecting all the nails at one time.

DR. TAYLOR said that in fourteen years' service at Charity Hospital the most typical case of syphilitic onychia which he had seen, was the one reported and pictured by him in the *JOURNAL OF CUTANEOUS AND VENEREAL DISEASES*, January, 1888. It was also the most extensive. He had also seen gummatous infiltration of the matrix occurring less than one year after infection. He did not think that Dr. Fuller's case was one of syphilitic onychia.

DR. ELLIOT then said that he would like to report the result of the microscopical examination and the course of the case of lupus vulgaris of the nose, which he had presented to the Society at the February meeting. He did so because there had been quite a general expression of opinion that it was syphilis, and also because of the age of the patient before the disease began. The patient had been put on mixed treatment, but no result was obtained. A portion of the ala was scraped off, and under the microscope tubercular tissue was found, and in sections stained by Ehrlich's method tubercle bacilli. Besides, the patient had been vigorously treated with the sharpened pencil of nitrate of silver, and a large portion of the affected tissue had cicatrised. In this cicatrix, the characteristic brownish red tubercles of lupus had begun to develop.

DR. FOX said that he would like to refer to the case which had been presented by Dr. Jackson as morphea at the 177th meeting of the Society, and which had been considered as atrophy of nervous origin. He stated having found an exactly similar case published in Dr. Hutchinson's late book.

He also said that in Dr. Jamieson's book there was a lithograph showing the same appearances as were seen in the case shown by Dr. Lewis at the same meeting. He had called it morphea and was pleased to find that Dr. Jamieson considered his case to be circumscribed scleroderma.

The Society then went into Executive Session.

## Correspondence.

### Clinical Notes: The Treatment of Eczema, Ivy-poison, and Herpes.

*To the Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.*

SIR—I will venture to recommend a few remedies in the treatment of some diseases which are very common, but which are at times very difficult to control by the means commonly employed.

1. Eczema: I have had uniform success in treating all forms of eczema in all stages, with an ointment composed of iodide of lead and vaseline, in the proportion of 20 grains to 1 ounce. It should be applied once or twice daily to the affected parts, and washed off once in forty-eight hours, in order to prevent rancidity. The parts should be dried quickly with a soft towel and the ointment re-applied. More frequent washing is harmful; the parts should be kept as dry as possible. In the case of infants with tender-skins, the ointment may be one half the strength used for adults. Disorders of the secretions or of the general economy should be corrected, but special internal medication I believe to be useless. Sulphur ointment sometimes answers a good purpose, especially upon the scalp; also chrysophanic acid in old cases with much induration—2 to 5 grains to 1 ounce is strong enough. Ordinarily, however, the lead ointment is all that is required locally. In case the surface involved is very extensive, I suppose care should be taken to avoid lead poisoning, although I have never seen it to occur under the employment of iodide of lead.

2. Poison from rhus toxicodendron: The poisonous action will usually be arrested at once by the employment, locally, of equal parts of fluid extract of grindelia robusta and water, or even in weaker solution. The remedy may be used in full strength if the weaker preparations fail of success.

3. Herpes: Bromide of sodium in doses of 10 grains every three or four hours, will ordinarily arrest the progress of a case of "shingles." The vesicles usually begin to dry very soon after the treatment is instituted, and the excoriated or raw points soon become healed. Some forms of pemphigus will yield to the same remedy.

CHAS. H. RICHMOND, M.D.

LIVONIA, N. Y.

### Treatment of the Vesico-Urethral Erethism of Locomotive Engineers.

*To the Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.*

SIR—In treating the backache usually accompanying "Vesico-urethral



erethism peculiar to locomotive engineers," I find mechanical support of the lumbo-sacral and sacro-iliac joints of great benefit. With the patient standing erect, firmly draw back the crests of the ilia and apply two inch strips of rubber adhesive plaster horizontally across the back, extending around two inches in front of the anterior superior spine of each ilium.

I use from four to six strips, lapping them to make a pad about four inches in width. A broad abdominal belt drawn tight is also of service. In one case where the pain was so severe as to make the patient "sick at his stomach," I applied with excellent results a stout narrow "corset" about the hips and abdomen; the "corset" being well boned with broad flat steels in the lumbo-sacral region.

G. L. HUTCHINSON, M.D.,

COLTON, CAL.

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## Selections.

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### XERODERMA PIGMENTOSUM.

FROM an elaborate paper read by Dr. R. W. Taylor, before the New York Academy of Medicine, we make the following extract:

In 1870 Hebra and Kaposi first published a description of the disease and called it Xeroderma. In 1877 and '78 Dr. Taylor read papers containing the histories of seven cases of this disease before the American Dermatological Association, but did not then publish them, preferring to watch the cases over a long period of years, so as to thoroughly study their course before doing so.

The literature of the subject includes forty-one cases—two observed by Hebra and Kaposi, two by Geber and Kaposi, four by Kaposi, one by Heitzman, one by Duhring, two by Neisser, six by Ruder, quoted by Neisser, five by Vidal, three by Pick, three by Crocker, two by J. C. White, one by DuBois-Havenith, and seven by the author. The disease has been called by several names. The provisional name first given by the author was *Angioma Pigmentosum et Atrophicum*, but in 1882 Kaposi published a paper on the subject in which he called the disease Xeroderma Pigmentosum, and this name is now generally accepted.

*Clinical Features:* The disease consists in the telangiectases, the pigmentations and atrophic changes all having intimate pathological relations. As sequelæ three are new growths, at first benign, but may become malignant.

*Age:* Many observers have failed to state or learn the date of invasion, but in twenty-six of the recorded cases it began before the end of the second year. In six of the author's cases the disease began about the sixth or seventh month, and in the seventh case at the fourteenth month. The weight of evidence, therefore, places this disease as one of early childhood.

*Invasion:* The disease begins about the face, as a smooth, superficial erythema, looking like a sunburn, and with no impairment of health. The erythematous patches gradually creep over the face and neck, usually stopping with an abrupt margin about the third rib. This condition lasts from one to several months. As this prodromal hyperæmia disappears, pigmented spots or telangiectases, appear irregularly over the affected regions. These spots

are at first light brown, but turn darker, even black. These are about the size of a pin-head, slightly, if at all, elevated and of irregular shapes. Scattered among these pigmented spots are the red or telangiectatic spots, less numerous, smaller and very irregular in outline, but containing congeries of capillaries.

The hands may be similarly affected, but always to a less degree. The pigmentation is always a sequelæ to the red lesion, as is demonstrated by the microscope.

The further lesions are erratic, they come and go, but never entirely disappear, the disease becoming, more or less rapidly, worse.

The period of activity is greatest in very early childhood.

Atrophic changes are soon superadded to the pigmentations, usually at the end of the first year of the existence of the remarked changes. They occur on both sides of the body, but are not symmetrical. They often produce hideous deformities by reason of the size and situation of the patches. The skin is rendered as thin as parchment and nearly all the follicles are destroyed. Minute lines traverse these patches which are frequently so transparent that the vessels can be seen beneath.

Upon the hands and feet atrophy is not so marked, except where the skin is stretched, as over the knuckles. In these atrophic patches there is a constant evolution and involution of the telangiectatic spots, often followed by pigmentations.

The atrophy of the skin is in proportion to the atrophy of the minute vessels, and its activity to the development of the red spots. The process goes on until all the vessels in the skin have undergone increase and decay. Atrophic changes occur especially about the forehead, nose and eyes, due, no doubt, to the excessive vascularity and exposed position of the parts, and, as a result, ectropion, partial stenosis of the nasal apertures and other deformities occur. When the atrophic process is complete no further pigmentation occurs and a smooth, white shining surface is left.

Hypertrophic changes take place, often coincidentally with the atrophic process.

Epithelial new growths occur, consisting of plaques, looking like keratosis senilis, which may be the starting point for larger growths. At the junction of the skin with the mucous surfaces their tendency is to form malignant tumors.

About the face they form sessile or pedunculated tumors, whose surfaces, after shedding off their pigmented epidermal covering, are fungating.

They are at first reddish or purple in color, soft and compressible, like erectile tumors, but frequently become brittle and pale, and falling off, leave ulcers which may heal easily or extend in depth, surrounded by hard, everted edges, becoming the seat of malignant degeneration.

The period of greatest malignancy is under ten years but nearly as great until twenty years. These tumors are of great variety and often the seat of hemorrhage. They are often very malignant, but there is no evidence of metastasis.

*Pathology:* The pigment is similar to that of melanotic new growths.

The little yellow, warty elevations undergo corneous transformation and are accompanied by a rapid increase of capillary vessels. The atrophic condition is like that of senile atrophy of the skin. With atrophy of the

epidermis there is absence of pigment, which when it is thickened there is much pigmentation. This production of pigments depends on the alteration of the vessels in the skin.

In the superficial layers of the derma, embryonic cells are abundant, together with a large quantity of elastic fibres in the deep layers of the papillæ, which may have replaced the atrophied connective tissue.

In the majority of the pigmentations the cell increase is not great, but in the keratotic patches it becomes constantly more abundant. In the fawn or light colored pigmentations, the vessels are dilated and distended with blood and they owe their origin in the red spots. In the keratotic or warty patches, there is much variation in the amount of all infiltration and vascular change. This explains why some tumors are vascular and others firm and dry. The occurrence of epithelioma at such early ages is due to the rapid changes going on in the epithelial layer of the skin, in the production and rapid disappearance of new papillæ and epithetum, and of the pigment-carrying elements.

*Treatment:* No case of xeroderma has ever been cured. Our measures should be directed toward placing the skin at rest, and removing any possible source of irritation to the morbid parts.

Knowing that these pigmented warts are so apt to become malignant, they should be removed as soon as possible with the sharp spoon. In fact, all tumors, whether large or small, should be removed as early as possible.—*The Medical Record.*

#### ON PREVENTIVE TREATMENT IN PRIMARY SYPHILIS.

THIS is the subject of a paper by Dr. Bronson, recently read before the New York Academy of Medicine. The main body of the paper is devoted to an argument in favor of the proposition that during the primary stage syphilis is essentially a local disease. With regard to the doctrine of syphilitic infection, the writer expresses himself as follows :

" While it can not be affirmed of any period in the course of the malady that the disease is strictly limited to the site of the initial lesion, the proposition that syphilis is essentially a local disease remains still uncontroverted. The periods of incubation preceding the following development of the chancre correspond to what we may provisionally term a process of germination that takes place *in situ* and not in the general circulation. During the forming stage of the chancre, during the period of apparent quiescence, and before any changes at the point of inoculation are outwardly preceptible, certain alterations are doubtless in progress : the round cells are accumulating, the walls of the blood-vessels are being infiltrated and occluded, till at length the initial lesion is formed. Meanwhile it is not unlikely that certain infectious elements find their way in small quantity into the general circulation. A few such germs might possibly be at once destroyed or eliminated from the economy, but they would gradually increase as the initial lesion and the affected glands continually added to the supply, and, sooner or later, their influence upon the tissues would be such as to superinduce that condition or modified infection which suffices to secure immunity against reinoculation, but is insufficient to elicit constitutional symptoms. Finally, re-enforced by larger and larger incursions of infectious matter, it accumulates in the blood in such excess that the organism, unable to tolerate it longer, reacts with the characteristic manifestations of general disease."

Thus regarding the course of syphilitic infection the writer next approaches the question, preventive treatment. It had been intimated at the start that an answer to this question might be equally valid whether based on theoretic or empirical grounds. But the results of experimental investigation had been found so contradictory or ambiguous, as to be of little value practically. So far as the theoretical side of the question was concerned it was claimed that the indications were not without promise. "An infection," he says "whose limits are circumscribed and more or less definable is a very different thing from one that has already taken possession of the entire organism. In the ordinary affairs of life it is deemed a much simpler task to remedy an evil at the outset, than after it has gained headway and become confirmed." Nevertheless a large proportion of the authorities on syphilis advise purely an expectant treatment. The writer admits that preventive methods, hitherto proposed, afford little hope of success. Of ectrotic treatment he says :

"Excision of the initial lesion may have accomplished something. Certainly, when practicable, it is a perfectly rational, safe, and proper surgical procedure. It is removing an annoying symptom and a possible source of danger to others. Regarding the chancre as a depot of generation and supply of virus to the economy at large, its removal has another purpose, though, for considerations already given, with but small outlook of success. In a few instances excisions of inguinal glands together with the initial lesion have been reported, but thus far without noteworthy result. It is extremely doubtful whether an operation to include every indurated or infected gland would be practicable. The inguinal adenopathy is rarely or never recognized as a monadenitis, but as soon as any enlargement at all is felt it plainly consists of a lymphatic group, and how many glands in any given case this group would include, and how far it would require the operation to be extended, it is difficult to surmise. In the three specimens described by Fournier and already alluded to, the number of glands affected varied from eleven to sixteen. In one specimen there were seven inguinal and four iliac glands ; in the second, six inguinal and nine iliac ; and in the third, eleven inguinal and five iliac. Manifestly in these cases the extirpation of all the affected ganglia, both inguinal and iliac, many of the latter occurring high up above the crural arch, would have been out of the question."

There are also objections to constitutional treatment during the primary stage. To some of them little importance is attached. Some authorities who admit that mercury may delay the advent of the secondary symptoms deny its utility on the ground that the delay does not prevent the disease from displaying ultimately the same virulence that it would if left alone, while at the same time it may prolong uncertainty in the diagnosis. Others indeed have maintained that when mercurial treatment is begun during the primary period the subsequent course of the disease though retarded is more apt to be severe ; the late symptoms are rendered graver by this early treatment. "But there is an inconsistency" the writer observes, "in the idea that for the month or so of primary syphilis the same remedy is to be shunned, because of dangerous after-effects, whose continued employment during the years of the constitutional disease is accepted without demur."

On the other hand "those who believe in a primary local infection, have depreciated constitutional treatment for the local disease on the ground of its indirectness. It was subjecting the system to a toxic remedy before there

was any systemic trouble ; it was offering the antidote before the poisoning had taken place." To this it is objected that mercury is often administered internal with unquestionable effect for strictly localized lesions. Nearly all admit that when the initial lesion is formidable in size or slow in yielding to local measures, a mercurial course will hasten its involution. "It must be granted though," the writer says, "that it is taking a very round-about road to reach the result. In localized affections generally, which are not symptomatic of systemic disorder, our main reliance is always placed upon the topical treatment, though an adjuvant effect may be derived from internal medication. In primary syphilis the disease is essentially a local one. While it is conceded that a certain degree of infection may exist in the blood, it is extremely doubtful if by internal medication it is possible to reach it. We know that mercury cures the symptoms ; that it cannot be relied on to prevent them is an every day experience. It is possible that mercury is the direct antidote to the syphilitic virus. Granting the hypothesis of the parasitic nature of the virus it is not unreasonable to infer that the efficacy of mercury in syphilis is attributable to its germicidal action. Whether, finally, this will be shown to be its only virtue in this disease is doubtful, and it will remain to be explained why this virtue is not displayed in a similar manner in other infectious diseases of a zymotic nature, such as lepra and tuberculosis. But, supposing that mercury does act as a germicide in syphilis, it is very questionable whether it could have any effect upon germs circulating in the blood. Much more probable is it that the effect would be exerted where both the germs and the mercurial would be most apt to accumulate, as at such places of elimination as the skin, or where deposited in the tissues. That mercury does exert a most decided influence upon the local manifestations of syphilis, when topically employed, we have undoubted evidence ; then why should not this potent influence be brought to bear directly upon those local lesions which are also dangerous foci of infection in the primary period of the disease ?"

In conclusion a method of "regional" treatment is proposed, designed to accomplish "a more direct employment of mercury in the region where the chief source of danger has its seat."

"The scheme consists in the local use of antisyphilitics by a method designed to bring the remedy or germicide in direct communication with the whole of the affected region in primary syphilis, including more particularly the initial lesion and the diseased glands. As commonly employed, the regional treatment has consisted simply in the use of mercurial hypodermics beneath the initial lesion (except this lesion be excised) and into the mass of the indurated lymphatic glands. But the plan may be easily extended. The field of operation may include all of that district whose lymphatic vessels tend in their course toward the ganglia which are the seat of disease. When the initial lesion is situated upon the genitals, the area most available would consist of the external genitals, the perinæum, the upper, inner and anterior aspects of the thighs, together with the inguinal region and lower part of the abdomen. By multiple small subcutaneous injections and by inunctions within this area the remedy may be introduced little by little into the lymphatics with the hope of its being conveyed in sufficient amount to the diseased glands to destroy the infectious germs, or to retard their multiplication.

The only agent thus far employed for this purpose is mercury. Notwith-

standing its irritant properties are a great hindrance to its use, no substitute for it has yet been found. The question that concerns us at present is how to introduce this irritating substance into the affected region with the least amount of offense to the normal tissues, but in sufficient quantity to exert its antidotal or destructive influence upon the germs of the disease. Where hypodermics are used it is not necessary that the drug be injected in large quantity in any one spot, nor in a concentrated form. A twentieth of a grain or less of the bichloride introduced in separate injections of not over a hundredth of a grain each would afford a more reasonable hope of effectively reaching the seat of the disease than a much larger dose given by the mouth. I have used a solution of one part in four hundred or five hundred parts of mucilage and water, with a small quantity of common salt added. Of this, four or five injections are made of four or five minims each, distributed over different parts of the cutaneous area above described. The discomfort caused by the injections is insignificant, especially if caution is taken to prevent any escape of the fluid into the corium. Similar injections may be made beneath the primary induration, when it is not excised, and into the substance of the indurated glands. The number and frequency of these injections will depend on circumstances and on individual judgment. Into the skin of the abdomen and thighs they may be repeated daily or every second or third day. Together with the injections, but more especially in situation where the former are less admissible, as in the perinæum and over the penis and scrotum, inunctions also may be employed, and for this purpose a mercurial soap will be found preferable to the mercurial ointment."

Dr. Bronson gives no statistics in connection with his suggested plan but claims to have sufficiently tested its feasibility. It is solely on the ground of its reasonableness that the method is advocated, and as an expedient to be preferred to the expectant plan which in adherence to an unfounded "dogma" would leave the patient "without succor and without hope during what may be the most momentous period of his disease."—*New York Medical Journal*, March 24, 1888.

### PHENIC ACID TREATMENT OF VARIOLA.

DR. MONTEFUSCO, of Naples, who during the past two years, since small-pox has been so prevalent, has had excellent opportunities to observe the effects of remedies, writes in the *Bulletin Général Thérapeutique*, April, 1888, that he has found phenic acid as a local application of value in calming local pains and exercising a beneficial effect on the course of the eruption. It is, however, as a remedy for internal use that he praises phenic acid, the adult dose being from one to two drachms in the day, well diluted. The first effect noted is upon the temperature—after a half-gram dose the temperature begins to fall and may go down two degrees. The number of heart beats is at the same time diminished but the force of the beat is increased. This remedy is the only one of many tried by the author which exerts a sure influence on the eruption itself. This influence consists in the moderation of the extension as well as upon the duration of the eruption. The production of pus is limited and the period of suppuration is shortened. Even when the eruption is confluent this modification is evident. The pustules dry up in a few days and are never accompanied by an extensive swelling of the sub-cutaneous connective tissue. Hemorrhagic small-pox is not benefited to any extent by this treatment. The good results are explained by the antiseptic

properties of the drug. In no case were there any symptoms of intolerance of the dose or poisonous effects noted, but on the contrary the general condition and feelings of the patients were improved. Albumen in small quantities was occasionally found in the urine, which would become darker after exposure to the air for a time, because of the acid eliminated in it. Nervous affections contra-indicate the remedy's employment.

### IS CANCER CONTAGIOUS?

FACTS have already been presented which tend to show it to be so. So far, we have only presumptive evidence, but it is quite probable that this will in the near future be changed to certainty.

Dr. Budd writes to the *Lancet*, that a patient of his, who had an epithelioma of the lip and refused operation, owned a terrier dog, which was his constant companion and often licked his face. This dog died before his master, of a cancer of the tongue.

Dr. Clemow has seen in the Royal Hospital of Liverpool, a man who died of cancer of the penis and testicle, apparently contracted in sexual intercourse with his wife, who suffered from cancer of the neck of the womb. Similar cases have been reported.

The case is related of a patient with cancer of the uterus and vagina, who was nursed by a healthy, robust servant who washed all the soiled linen. Six months after the death of the mistress, the servant was received in the North-Devon Hospital, with a cancer in the axilla, of which she died.—*Bul. Gén. de Thèrap.*, April 15, 1888.

### MALIGNANT TUMORS OF THE PROSTATE.

NEOPLASMS are in 90 per cent. primitive. In 10 per cent. they affect children from the age of 1 to 10.

Carcinoma furnishes 86 per cent.

Sarcoma is exceptional.

The connections of the gland and its abundance of lymphatics, explains the almost constant and rapid spread—(diffuse prostatopelvic carcinoma).

Implication of the bladder is exceptional.

The predominant symptoms are functional disturbances of the urinary apparatus.

Hæmaturia is often absent.

The younger the subject, the more rapid the course.

The evolution varies from three months to five years.

The exploration of the pelvic cavity and the existence of radiating pains, form the best basis for diagnosis.

The gravity of prognosis, and the severity of some symptoms warrant operative interference, but, on the other hand, removal of the tumor is useless, on account of the rapidity of diffusion.—Dr. Engelbach, *Thèse de Paris*, 1888.

### ANTHRAROBIN.

PROFESSOR LIEBERMANN in October last placed some of this new substance which he had discovered in the hands of Dr. Behrend of Berlin, for experimental trial. Because of its chemical composition resembling chrysarobin so closely, it was thought that its therapeutic worth would be found in the treatment of those diseases in which chrysarobin and pyragallol

had been found so useful. Anthrarobin as placed on the market by Jaffé, and Darmstädter is a light, odorless, yellowish-white powder of a granular nature causing a burning irritation when in contact with the nasal mucous membrane. It can be made into ointment with lard or lanoline after being well rubbed up in olive oil. Slightly soluble in water but freely so in a borax solution or in alcohol, it dissolves in ten parts of cold and in five of boiling alcohol, giving a dark brownish-yellow color. It can also be dissolved in ten parts of glycerine at a temperature of 100° C. The following formulæ are given :

R Anthrarobin.....	5.0
Ol. Olivarium.....	10.0
Axungæ porci.....	35.0
R Anthrarobin.....	10.0
Ol. Olivarium, Lanolini.....	20.0
R Anthrarobin.....	5.0
Alcohol.....	45.
S. in baln. aq.....	
R Anthrarobin.....	10.0
Glycerini.....	40.0

Salve in baln. Aq. S. Ten per cent. anthrarobin glycerine. In these and other forms with borax such as a solution containing anthrarobin 10, boracis 8, aquæ destil 80, will the drug be found to be well borne and not produce irritation as does chrysarobin. It can be applied to the face and even the eyelids for weeks at a time without causing any œdema or conjunctivitis. It does cause however, a yellow discoloration of the skin, but this does not extend beyond the place of application as in chrysarobin. A slight burning sensation is also experienced for a few minutes or more, but never enough to prevent its use in children. Like chrysarobin it dyes the clothing. Behrend employed the remedy in fifteen cases of psoriasis, seventeen of herpes tonsurans, two of erythrasma and one of pityriasis versicolor. He found the alcoholic solution far more active than the salves and it has the advantage of drying at once upon the skin and not staining the clothing so much. The borax glycerine solutions were but little used and judgment cannot as yet be pronounced. The effect was heightened when the diseased parts were rubbed with spiritus saponatus kalinus or potash soap before its application. The effect was weaker than that of chrysarobin and treatment was consequently more prolonged, but patients who had formerly used chrysarobin preferred the new remedy. It was used in psoriasis of the face and scalp where chrysarobin could not have been, and in general psoriasis gave good results.

In herpes tonsurans the 20 per cent. salve and the tincture were used and always brought about a cure after from ten to fifteen applications.

The author has previously shown that by treating erythrasma with chrysarobin it can be cured in as many days as it takes weeks and months, by any other means. Here too anthrarobin caused a cure after fifteen applications.

On the whole the new remedy seems to have given ground for further investigation and as it is somewhat cheaper than either chrysarobin or pyrogallol will find favor if further trial confirms these observations.—*Vierteljahres f. Derm. und Syph.* No. 2, 1888.



**NEUROPATHIC DERMATOSES.**

PROFESSOR CAMPANA treats in a masterly way the subject of neuropathic dermatoses, basing his article upon the observation and study of five cases which include one of multiple small cell sarcoma of the skin, two of primitive pigment sarcoma of the skin, and two of primitive teleangiectasic sarcoma of the skin, one being accompanied with peripheric and multiple neuromata. From a clinical and histological study of these cases, he believes that these forms of sarcoma of the skin are usually accompanied by a sarcomatosis and fibromatosis of the peripheric nerves, and it seems very probable to him that these nerves have an influence upon the distribution and reproduction of other sarcomata of the skin. The following conclusions are made:

1. That changes in the skin and nerve trunks are found dependent upon sarcoma.
2. That the changes in the nerves are often of more ancient date than those of the skin.
3. That many blood and lymph angiomas are distributed in the course of certain nerves.
4. That many fibromata of the skin bear a relation to neuromata and fibroneuromata (Recklinghausen).
5. That sarcoma of the skin, with which we are now engaged, appears in a symmetrical manner like an exanthem, or like the various forms of erythema whose neurotic origin is now admitted by dermatologists (Lewin), and frequently corresponds in its advances at the periphery to definite nerve trunks.
6. From the discovery that in this neuropathic form, elements of new formation appear which do not have all the characteristics of an aggregation of sarcoma cells, and from the observation that these elements among other things, are susceptible to the curative effect of arsenical preparations (Köbner) as we have ourselves noted.
7. From the discovery that the points at which an especial collection of indifferent cells has taken place in the skin, nerve terminations with sarcomatous swellings also appear.
8. From the observation that the disease often precedes, or is accompanied by repeated eruptions of urticaria or among other things a pruritus of the extremities, disturbances which can only be ascribed to the nervous system.
9. From the excessive pain which the patient experiences in the affected parts and in the course of nerve tracts which correspond with many of the diseased areas, especially on pressure.
10. From the fact that in these forms of sarcoma, the period of hyperplasia and the period of atrophy will be observed; the atrophy without the production of ulceration, which is a rarity in other forms of sarcoma, in which we for the most part see either ulceration or definite development of the tumor with a degeneration which is peculiar to it.

**PATHOGENY OF URTICARIA.**

UNNA has found in urticarial wheals which he produced with nettles upon his own person, and then excised, that the migratory cells are no longer present as in healthy skin, and hence concludes that they have no part in the formation of the wheals. To explain these, he advances the hypothesis of a spasm in the large veins of the skin which are provided with muscles,

whereby a stasis takes place in the lymphatic circulation of the skin. The pathological appearance of the wheal, Unna says, coincides with a perverse innervation of the vasomotors; that is, such an one as leads to spasm of the veins, with or without slight narrowing of the arterial blood vessels. No paresis follows upon a primary contraction, as Schwimmer and Vidal have believed. The wheals are, in the beginning, always red, and there is always and in all forms of urticaria a paresis, an enlargement of all the blood vessels, arterial as well as venous, is always present; but in those predisposed to urticaria the small veins of the skin contract.....Anæmia, however, does not result, but a wheal. In the classification of the various forms of urticaria, according to Unna, we must distinguish between the constant predisposition to venous spasm, which forms the foundation of all urticarial eruptions, and the single exciting irritation. The constant predisposition can be due to central or peripheric causes.

From this point of view Unna divides urticarial eruptions into the following four forms:

1. Universal predisposition due to central causes.

A. Urticaria traumatica.

B. Urticaria commune, chronica et acuta.

C. Urticaria factitia.

2. Local predisposition, due to peripheral causes.

D. Urticaria pigmentosa.—*Centralblatt für Klin. Med.*, November 6, 1887.

### ANOMALIES OF THE GENITAL ORGANS IN IDIOTS AND EPILEPTICS.

In an observation of 728 cases of idiots and epileptics, Drs. Bourneville and Sollier (*Le Progrès Médical*, February 18, 1888), show, by extensive tables, that anomalies and malformations of the genitals are frequently encountered.

Above the age of thirteen there were 172 idiots, etc., without epilepsy, and 333 with epilepsy.

Below the age of thirteen there were 164 idiots, etc., without, and 59 with epilepsy.

The anomalies presented included phimosis, hypospadias, varicocele, arrest of development, or atrophy of one or both testicles, etc., etc. In a certain number of cases the glans was club-formed, and compared by the authors to the clapper of a bell.

The meatus was occasionally found circular, very small, and situated exactly in the centre of the glans.

The smallness of the testicle seemed to be due to arrest of development rather than to atrophy in most cases.

Out of the *first category* of 172 idiots, imbeciles or weak children, 55 showed anomalies, including 19 phimoses, 6 hypospadias, 10 atrophies of the testicle, 7 double atrophies, 3 ectopies of the right testicle and 2 of the left, and ten double, 4 cases of bell-clapper extremity of penis and 2 varicoceles.

In the *second category* of 333 cases, were found 27 phimoses, 6 hypospadias, 21 varicoceles (left), 1 right, and 2 double; 13 atrophies of the testicle, 9 bilateral atrophies, 5 double ectopies, 2 varices of the glans, and 2 club-shaped glans.

In the *third category*—idiots, imbeciles and weak-minded boys without

epilepsy, and who had not yet reached the age of thirteen—we find 91 out of the 164 presenting such anomalies as we have already described ; 48 had ectopia of the testicle of both sides, and in 39 cases the testicles could not be felt at all, and in some of these cases may have been entirely wanting. In the *fourth and last category* the proportion of anomalies surpasses that of all the others, reaching nearly 68 per cent. Out of 59 cases with epilepsy 40 showed anomalies. In two cases there was complete adhesion of the prepuce to the glans.

The frequency of the anomalies is found thus to be more frequent in those cases than in well-balanced individuals. The physical and intellectual degeneration produced by epilepsy seems to influence the production of varicocele, for idiots without epilepsy present scarcely any cases. Idiots frequently have a malformed club-shaped glans not always acquired by onanism, for some of the subjects were shown not to have practiced it.

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### Items.

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**VACCINATION IN THE HAREM.**—The women in the Sultan's seraglio, at Constantinople, have just been vaccinated to the number of 150. The operation took place in a large hall, under the superintendence of four gigantic eunuchs. The Italian surgeon to whom the task was confided was stationed in front of a hugh screen, and the women were concealed behind it. A hole had been made in the centre of the screen, just large enough to allow an arm to pass through ; and in this manner the arms, of various colors and sizes, were presented to the operator, in rapid succession. It was utterly impossible for the surgeon to get a glimpse of his patients ; but, in order to guard against the chance of his being able to see through the screen, two eunuchs, who stood by the operator, threw a shawl over his face the instant an operation was concluded, and did not remove it till the next arm had been placed in position.—*The Indian Medical Gazette*.

**ERUPTION FROM THE INTERNAL USE OF ARSENIC.**—Dr. Leontowitsch reports a case of eruption from internal use of Fowler's solution, occurring in an old lady, the dose being a small one administered twice daily for the relief of obstinate chills and fever. On the second day severe itching manifested itself on the neck and chest ; on the third day a small macular red exanthem appeared upon the above-mentioned regions, the skin being slightly swollen and the seat of intolerable itching. By the fifth day, it had spread over the abdomen. Upon discontinuing the remedy, the cutaneous symptoms disappeared in three or four days, but were reproduced as before on taking the arsenic a second time. It was subsequently shown that while the patient could not tolerate either arsenite of potassium, or arsenious acid with bromide of potassium, arsenite of quinine caused no unpleasant symptoms.—*American Journal of the Medical Sciences*.

**BISMUTH POISONING.**—A case recently occurred in France, in which it is alleged that the application of pure subnitrate of bismuth to ulcers following a burn, at intervals of two days, caused sore throat with false membrane on the uvula, palate, and tonsils, foul breath, vomiting, and loosening of the teeth.—*British Medical Journal*.

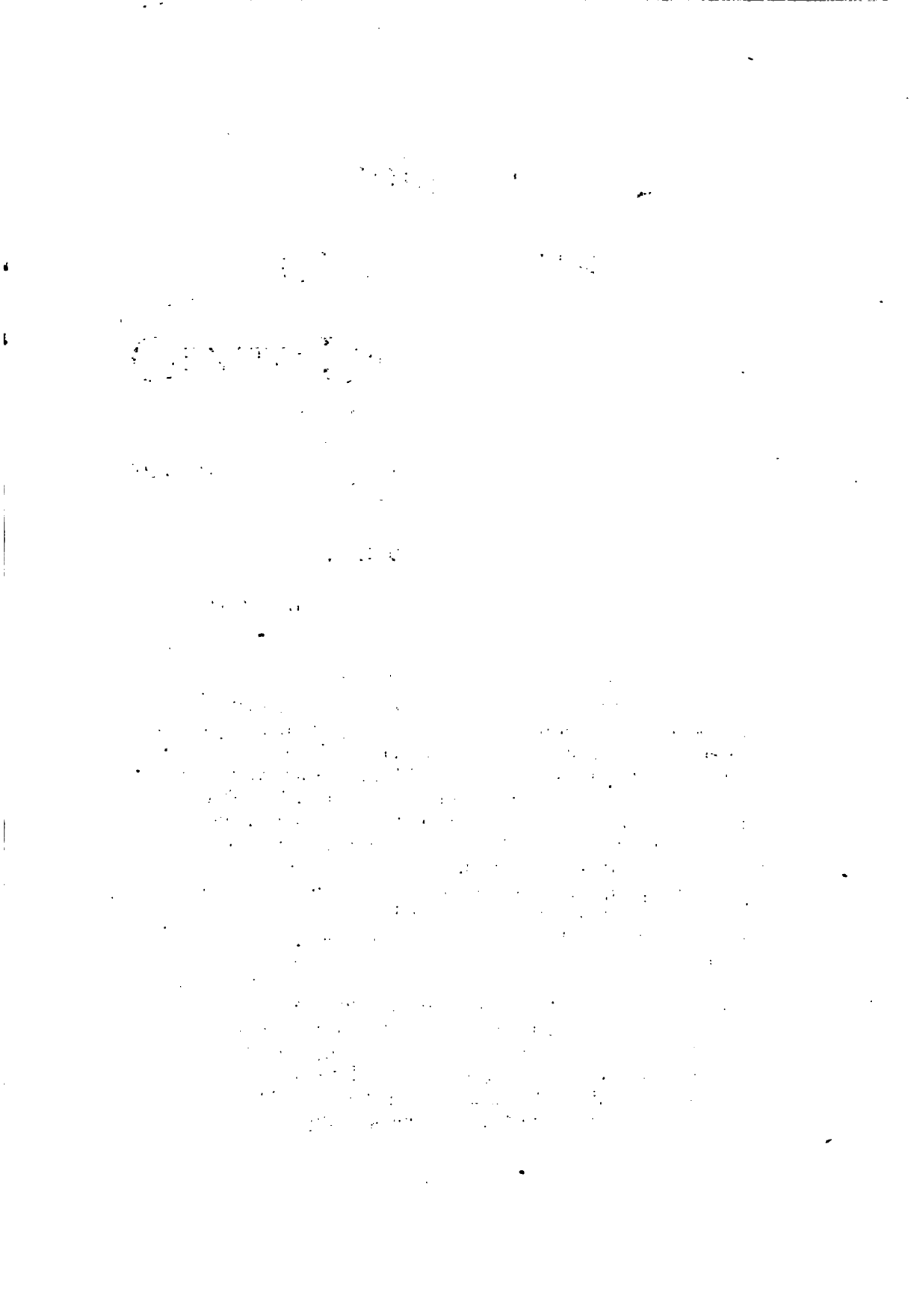
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- ONE Year of Dermatology. Report of the Department for Diseases of the Skin in Charity Hospital, New Orleans, 1887. By Henry William Blanc, M.D.
- CLINICAL Notes on Pruritus, by L. Duncan Bulkley, A.M., M.D. Reprint.
- ON Preventive Treatment in Primary Syphilis, by E. B. Bronson, M.D. Reprint.
- DOUBLE Comedo, by A. H. Ohmann-Dumesnil, A.M., M.D. Reprint.
- A CASE of Indigenous Leprosy, by Ohmann-Dumesnil, A.M., M.D. Reprint.
- THE Improved Cesarean Section, by Henry J. Garrigues, A.M., M.D. Reprint.
- SUPPURATIVE Exfoliative Cystitis, by H. J. Boldt, M.D. Reprint.
- INTERSTITIAL Nephritis, by H. J. Boldt, M.D. Reprint.
- REPORT of six cases of External Urethrotomy, by W. N. Wishard, M.D. Reprint.
- THE Galvano-Cautery Sound and its Application, especially in Hypertrophy of the Prostate, with reports of cases, by Robert Newman, M.D. Reprint.
- SYNOPSIS of the Second Hundred Cases of Urethral Stricture treated by Electrolysis, by Robert Newman, M.D. Reprint.
- DES Erythèmes Polymorphes et des Nodosités Pseudo-Rheumatismales Éphémères survenant chez les Syphilitiques, par Henri Charles Aubert Testu, M.D. These de Doctorat Lille, 1888.
- CONTRIBUTION à l'Etude des Dermatites Professionnelles, De l'Eczéma des Fileurs et Varouleurs de Lin, par Charles-Joseph Lefebvre. These de Doctorat, Lille, 1888.
- SUR les Ulcerations Tuberculeuses de la Peau, par le Dr. Maurice Vallas, Paris. J. B. Bailliere et Fils, 1887.
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FIG. 2

*Dr. Morrow's Case of Serpiginous Syphilide.*







JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

JULY, 1888.

No. 7

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**Original Communications.**

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**THE SERPIGINOUS SYPHILIDE (ILLUSTRATED).**

BY

P. A. MORROW, M. D.

Surgeon to Charity Hospital.

A LARGE number of syphilitic lesions are characterized by a peculiar creeping tendency in their course and mode of extension. Many circinate and psoriasiform lesions of the papular type are formed by the development of new papules at the borders of a patch while resolution occurs in the centre. In the same manner the dry atrophic variety of the tubercular syphilide may creep over large surfaces. The term "serpiginous" syphilide is, however, restricted in its application to lesions whose mode of advance is by ulceration at the periphery with coincident cicatrization of the centre. The ambulant character of the ulcerative process rather than the histological characters of the lesions in which it originates constitutes the basis of its nomenclature.

Accordingly as it originates from a pustule, a tubercle or a gumma, it has been variously designated as pustulo-ulcerous, tuberculo-ulcerous, gummato-ulcerous, etc.

The serpiginous syphilide may be superficial or deep—it may develop *d' embleè*, without preceding neoplastic infiltration, or it may, and most frequently does, result from a breaking down of

tuberculous or gummatous deposits. Its chronological position is among the late manifestations, generally occurring from the second to the twentieth year. It may, however, develop as early as the fourth or fifth month of syphilis.

The photographs, from which the chromo-lithograph illustrating this paper was made, were taken from a patient recently under my observation at Charity Hospital. The following brief notes of the case are abstracted from the history book of the hospital:

"Joseph F. J., æt 47, single, laborer by occupation, was admitted April 6, 1888. Patient states that three months ago he had a sore upon the penis which healed in about a month. He denies all venereal history previous to this period, but states that some years ago he lost his voice from the effects of a heavy cold. Examination of the mouth and throat shows that the soft palate has been entirely swept away, with more or less damage to the surrounding soft structures, and the presence of isolated round, white cicatrices upon the integument indicates the existence of a former destructive process—the specific nature of which scarcely admits of doubt.

The patient states that the present trouble upon the abdomen began as a small red pimple, which gradually enlarged, and finally became ulcerated, forming a crust. The ulceration extended, healing in spots while advancing in others, until it presented the appearance seen upon admission. A similar history was given of the development of the lesions upon the neck.

The general condition of the patient not being good he was first placed upon 'Ward Tonic,' and extra diet with an application of carbolized vaseline to the lesions. With the improvement in the patient's general health the sores began to heal. Iodide of potassium 3 i. t. i. d. was ordered later, under which cicatrization rapidly took place, and the patient was discharged May 28th."

The superficial serpiginous syphilide commonly originates from a single pustule or tubercle, or a number of contiguous crustaceous pustules may run together forming a round or oval patch covered with crusts.

The mode of extension is as follows: As the ulcerative process advances at the periphery there is formed a ring of ulceration around the encrusted centre, the purulent secretion rapidly condenses into yellowing, greenish or blackish crusts which cover the ulcerated furrow. The central portion of the crust falls off leaving a pigmented cicatricial base surrounded by a rim of crusts, beyond which extends a coppery red infiltrated areola. This in time becomes the seat of ulceration, and as the

coincident central cicatrization keeps pace with the peripheral ulceration, we thus have a continually widening circle of ulceration inclosing a constantly increasing area of scar tissue. In this way the migratory ulceration may sweep over large surfaces.

Instead of this strictly centrifugal mode of extension one segment of the circle may entirely heal while the ulceration advances at the other portions of the circumferential border, producing crescentic, reniform or horse-shoe shaped patches.

The course of the serpiginous syphilide is essentially chronic when undisturbed by treatment. A definite end of the process may be determined by the internal use of specific treatment, supplemented by appropriate local medication.

Instead of the tubercular ulcerations uniting and forming a continuous furrow of ulceration, they may remain isolated and separated by cicatricial tissue or healthy skin, forming a broken or fragmented circle. Both forms may be represented in the same patient. In Fig. 1 there is seen upon the left lateral and posterior surfaces of the neck a number of ulcerating tubercles, forming a patch which advances from the front of the neck, backward upon the shoulders, in a semicircular sweep, the advancing segment shows a number of isolated and quite distinct ulcerating tubercles. In Fig. 2, same patient, the patch upon the abdomen is more irregularly oval in outline and centrifugal in its advance, showing a ring of crusts of almost uniform width, half-inch or more in height, surrounding a vinous-red cicatricial area.

The cicatrices which are left by the ulcerative process remain for a long time pigmented and finally become white. They are commonly smooth, and more or less depressed; sometimes, however, they are irregular, uneven, traversed by raised bands or cord-like processes, and may be keloidal in character.

The deep serpiginous syphilide differs from the preceding variety in the deeper-seated character of the lesions which serve as the focus of ulceration and the greater depth of the destructive process. Its chronological position is in a more advanced stage of the diathesis, but since there is often a coincident development of deep ecthymatous pustules and tubercles at a late period of syphilis, it may be difficult to determine which may have been the generating lesion.

Deep serpiginous ulceration is more commonly and characteristically developed from lesions of the tubercular or gummatous type. It may have its origin in a single tubercle, or, as is more commonly the case, from a number of nodules circularly

grouped. The older central nodules first undergo disintegration, suppurate and become surmounted by a crust. As the outlying satellite tubercles in turn soften and ulcerate, they run together, forming a continuous fossa of ulceration covered by crusts around the central lesions which are in process of cicatrization. New nodules shoot up at the periphery forming a belt of infiltration around the ring of crusts. This infiltrated margin is in turn ploughed up by a concentric ulcerative furrow, of more or less uniform width, appearing as it had been dug out by a gouge. The outer wall of infiltration is steep, perpendicular or undermined, the inner margin shallower and sloping, the base and edges secreting a purulent fluid which dries into thick more or less elevated crusts; the patch continues to enlarge so long as new tubercles develop at the periphery.

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THE LIMITATIONS OF ELECTROLYSIS AS A THERAPEUTIC  
AGENT IN ORGANIC AND SPASMODIC STRICTURE  
OF THE URETHRA, WITH CASES.<sup>1</sup>

BY

F. TILDEN BROWN, A.M., M.D.

MR. CHAIRMAN AND GENTLEMEN :

I FEEL that an apology is due for presenting, before this Section of the Academy, a paper upon a theme, with the status of which, it has long been so well satisfied.

If, before testing it in practice, I had reviewed the literature of the subject as carefully as since, I would have seen that no further evidence was needed to assure the incredulous of its narrow scope, and equally well have recognized the futility of hoping to convince its advocates of any self-deception in the matter.

The therapeutic use of this agent in stricture, was first attempted by Crussel and Wertheimber, who sought by it to relieve the peri-urethral swelling. Their efforts resulted unfavorably. After them, no one found encouragement, until Tripier and Mallez adopted galvanism as a potential cauterizer for the actual destruction of stricture tissue. In 1867 and 1870 they published forty cases all cured or improved. In 1870 Bautisto Campos recounted a number of successful cases; Couriari and Bruns likewise.

Inspired by the theories and results of these authors, two men of eminence in urethral surgery, Dittel and Keyes dis-

<sup>1</sup> Read before the Surgical Section of the New York Academy of Medicine.

missed it after a careful trial, and have fortunately given us a detailed account of their experience.

The cure said to follow electrolysis resulted from two causes. Stated briefly as follows:

*First.*—The destruction by cauterization of the constricting tissue, with a subsequent separation and shedding of this portion as a tubular cast.

*Second.*—The non-retraction of the denuded parts, because of a specific action upon the remaining tissues by the alkaline ions, which temper the nature of the resulting cicatrix by removing that quality of resiliency characteristic of scars produced by acids and the actual cauterization.

As the ten cases reported by Keyes in 1871 are so complete as to appear best in a tabulated form at the end of this article, I will here allude only to the closing remarks of his paper. After a complete repudiation of the practice, he says, "Organic stricture may be widened by the passage of the negative current. Reconstriction takes place after this as after all other methods. It seems to be utterly inapplicable to strictures at or near the urethral orifice. Symptoms are not relieved rapidly, nor in proportion to the pain of the operation."

Dittel's experience in three cases will be better shown by a description in his own words. "The first case was an ænemic person, æt 30, with a callous stricture at the outer portion of the urethra, and a second one in the membranous part. The case afforded a good opportunity of observing distinctly, with my own eyes, the catalytic action, for it was only necessary to hold apart the lips of the meatus after the operation was completed to see the results. The conductor introduced after the sitting did not however move forwards an iota.

The inner surface of both lips was pale, dull-white, as if scabbed. On the evening of the same day an increase of temperature and pulse rate supervened, but this may have been accidental.

In the second case—a callous stricture of the membranous urethra—electrolysis proved likewise inefficient. The conductor did not move forwards, and the introduction of an ordinary catheter was not rendered more easy. In a third case the electrolytic method was not only unsuccessful, but was followed by a local urethritis."

Except in the Latin countries this evidence of Keyes and Dittel was sufficient to seal the fate of electrolysis when used as a strong potential cauterization.

It was left, as an additional source of glorification (?), for America to first discover an hitherto unknown effect of electricity. Namely that of absorption.

This school we will now consider.

Dr. Robert Newman, of this city, claims to have made practicable the use of electrolysis as tried and abandoned by Crussel and Wertheimer. The secret of this success seems to rest in the motto: "Do not cauterize, only absorb." In numerous articles published since 1874 this author expresses, with slight variation, the same views and results.

One noticeable change is that at first he regarded callous strictures less amenable to electrolysis than the inflammatory congestive variety. He now holds that this method is applicable to strictures of all varieties and situations. It is however, proper to note that strictures of the anterior urethra have really given his school not a little trouble. Newman is the only author I have found who has been able to account for this difficulty; by him, the method is relieved of responsibility, as all such contractions are of syphilitic or chancroidal nature, requiring iodide of potassium. Surely it is to be regretted that strictures resulting from cell proliferations of this nature will not absorb. Newman classifies electrolytic treatment under three heads:

First.—"That by mild currents, used for a short time, at long intervals."

Second.—"The galvano-cautery, which is dangerous and unsuitable."

Third.—"A combination of the first and second, where a passage is forced by the action of a powerful current, with the immediate introduction and retention of a catheter to separate the walls and prevent adhesions."

This third method, that of the French school already alluded to, Newman "practices only when obliged to do so." That this *should* be very seldom may be inferred from his remark. "No one could think of curing stricture by cauterization." "Electrolysis may become caustic in its action, destroying tissues and leaving a denuded surface, which, in the healing process, throws out plastic lymph, fills up the cavity and forms solid and adherent walls."

To describe his view of the action of electrolysis, Newman likes the term "Galvano-chemical-absorption." Absorption he defines as "The process or act of being made passively to disappear in some other substance, through molecular or other

invisible means—as absorption of light, of heat, of electricity.” This vague suggestion pictures the disappearance of a stricture by either the instrument, the atmosphere, or the tissues absorbing it.

In looking over his tables of 200 cases of stricture “permanently cured” by this means, the great number of deep strictures is noteworthy. He accounts for this by being the recipient and refuge of the worst class of cases. It is, however, to the probable nature of many of these cases I would refer.

It is generally well-known that idiopathic, if not symptomatic contractions of the neck of the bladder, that is, the region between the vesico-urethral opening and the bulbo-membranous junction, are very easily confounded with organic stricture. In fact, at times, when the smallest instruments are refused, the contraction being so strong and lasting as to completely close the way, the differential diagnosis between organic and spasmodic stricture by this means is impossible. Individually I would not even limit spasmodic strictures to this tract.

Now, in alluding to different kinds of stricture, Newman says: “Spasmodic contractions of the urethra, usually called stricture, is not a real stricture, and has no bearing on, or relation to, the electrolytic treatment.” Thus, he wholly ignores what Prince, another advocate of electrolysis, urges as a most important consideration.

Butler, author of that oft-quoted sentence which predicts the early recognition of electrolysis as the acknowledged remedy for organic stricture, sought to make its claims final by the publication, in 1873, of an incomplete report of three cases cured by this means when all other methods had failed.

In articles reporting four cases, Dikeman repeats Newman’s rules as his own.

Overall recognizes two forms of stricture to be treated by electrolysis; the one hard and firm, which is easy to treat, although the calibre may be almost closed. The other, soft, tender and congested; these latter require preparatory treatment with soft bougies. For the hard, firm variety, strong currents of from eight to twelve volts can be used at once for from ten to fifteen minutes. Two or three treatments generally result in permanent cure.

He believes the irritable stricture, with its gleet, is cured by the mild current, changing the chronic or subacute into an active process. When complete absorption (evidently not Newman’s absorption) takes place, cure in the hard variety is effected by

the conversion of tissues into their original chemical elements, as well as by subsequent absorption.

Bryce says: "All strictures are amenable to the treatment by electrolysis." "A current which is just positively perceptible to the patient will not burn or cauterize, will not produce pain or inflammation, but will, with positive certainty, reduce the tissues in contact with the negative pole to their original elements. And what is the result? The stricture is absorbed without pain, without cauterization, but as it were by a chemico-vital process, and the electrode passes readily into the bladder because there is nothing left to obstruct its passage." Bryce's third case evidently had an unrecognized spasmodic element, for at one visit it was apt to refuse a small instrument, and at the next take one several sizes larger. "This demonstrates," *he* says, "what nature does for these cases after an absorption has been started by electrolysis, and the tissues are partly broken down." This sentence has a corollary, "This is true *in all cases*;" then a modification, "*as a general rule*, after a week or ten days patients will return with the calibre of their urethra from one to three sizes larger, than the electrode used at the last seance."

He hints at the difficulty of realizing the elusive compromise of Newman's law when he says: "The problem is to absorb the stricture, not to cauterize."

Anderson's article is noteworthy only from the result secured in his second case, in which, after nine month's treatment, a stricture was enlarged from six to eleven French. He says, "So far, no failures have occurred."

Morton reports a case of stricture complicated by fistulæ, which were caused, seemingly, not by the stricture, but by treatment for a cystitis by fixation of catheter. Fifteen days after electrolysis had been instituted, the stricture was cured and the fistulæ had not only closed, but scarcely any inflammatory thickening about them remained. Alluding to electrolysis, he says, "My own opinion is, that it acts through the trophic nerves, and sets up an increased vital action in the tissues."

Hutchinson is satisfied that he derives marked benefit from the use of electrolysis. He does not attempt any explanation of how it benefits, simply saying, "a powerful stimulus whose rationale or potential no man understands, must, as drugs, in a large proportion of cases, be used empirically."

Except Prince all the advocates speak of electrolysis as a



distinct entity in whatever benefit follows its use, wholly ignoring the necessarily associated factor of dilatation. Belfield exemplifies this in saying, "Except for strictures situated within an inch of the meatus, and for strictures of large calibre elsewhere, he considers electrolysis preferable to dilatation and and urethrotomy."

A striking inconsistency in the behavior of galvanism is shown by contrasting Belfield's experience with Newman's. The former says: "Since cicatricial tissue is but scantily supplied with blood, and is therefore poorly nourished, it yields to a dissolving current which is insufficient to disturb the healthy urethral tissues." The latter says, "Callous strictures are less amenable to electrolysis." \* \* \* "Blood and muscular tissue are good electrolytes, hence the inflammatory strictures yield readily to the electrolytic treatment. If the parts to be acted upon are devoid of water the action will be slow."

Three of Belfield's cases were "Impermeable to urine and impassable to instruments." In each a No. 10 electrode was passed into the bladder in less than twenty minutes, and with weak currents, which, as Belfield asserts, "When properly used the heat is insignificant, the cicatricial tissue is dissolved away, but not cauterized." After this sentence the kindly words of Dittel might be aptly quoted. "If I should ask," he says, "whether any one has ever succeeded by the electrolytic method in removing in the space of a few minutes an old connective tissue formation, the answer could probably justify, in every respect, my doubts as to the utility of the method."

Belfield used the method successfully in thirty-seven cases. He is not prepared to assert that the cures are permanent.

Steavenson, electrician to St. Bartholomew's Hospital, would appear to have an enviable opportunity to clear away much of the mysticism surrounding this subject. He and Bruce Clark claim to have verified in every particular the favorable accounts of electrolysis emanating from this country.

It is unfortunate for the integrity of this system that some of the statements of these authors, although probably perfectly correct, should be so much at variance with those taught here where Newman's electrolysis without chemical cauterization is universally maintained. Almost reconciled to this belief Steavenson bewilders us by saying, "Electricity, on account of its power of splitting up compounds into their chemical elements, can be used as a substitute for ordinary caustics to the human body. The treatment of stricture of the urethra by this method

is the most simple and perhaps the most striking in its results."

Although Steavenson does not state the time employed in a single seance, we must infer that it is a long one, for, with mild currents of from 3 to 6 milliamperes, he expects to produce effects resulting in the detachment of a slough or eschar a day or two after the operation. This suggests a combination of the French and American systems, where the French result is secured by the American means, only with the peculiarity that these weak currents have in his hand a caustic effect. This leads us to the serious mention of a fact too much ignored by writers upon this subject. I mean the relation of time to the effect produced by any given electro-motive force.

Another indication of the caustic power of these weak currents used by Steavenson is shown by the following sentence: "No force is used, but the electricity allowed to do the work. The surgeon has to keep his attention continually applied to the electrode, so as to guide it in the right direction; otherwise a false passage may be dissolved into the side of the urethra."

This same author says of the negative electrode: "Besides its service of applying the same destructive action as is caused by the caustic alkalies, it appears, in addition, to set up an absorptive action, so that cicatricial tissue gradually disappears." As evidence of this he claims that a stricture, after any one treatment, will accept at the next an instrument from one to three sizes larger. There are a number of ways of viewing and explaining such a statement, but, if it is meant as a direct assertion, applicable to the majority of cases, I must say that no experience of mine has lent any support to such a belief.

The claim of Steavenson, just referred to, is so extensively repeated that it suggests a contagious maxim passed from one advocate to the next, and by him fully accepted and repeated before he has had a chance to prove it.

Now, if this happy result does occur in Steavenson's cases, why should not the increased calibre be accounted for by the shedding of an eschar which he expects to follow on electrolytic treatment, or by allaying a spasmodic contraction, as claimed by Reliquet and Prince?

It is this one point, namely, that of subsequent resorption, which is the all-important consideration in this as well as every other method of stricture treatment. If it is favorably influ-

enced by what is called electrolysis then we possess the long looked for specific, and even if some urgent cases should require a preliminary urethrotomy it must be admitted that the usual after treatment would be most speedily conducted by this agent.

When we consider Vollemier's theory of the cure of stricture, with ordinary sounds, by what he calls, "Inflammatory dilatation;" a name he gives to a series of organic phenomena provoked in the urethral walls by the contact of a foreign body, and, which leads to atrophy and resorption of the tissues making up the stricture. When, I say, we consider, and probably accept, this theory, it is a very easy and pleasing inference to believe that the additional stimulation of the vital processes by electricity would greatly hasten and so thoroughly accomplish this resorption as to remove all possibility of return. If this happens in deep organic strictures, why should it not in anterior strictures, and those of large calibre, why not in cicatricial formations on the surface of the body? It is not pertinent for the champions of electricity to call in evidence cure of naevi, the shrinkage of fibroids, the consolidation of an aneurism, the obliteration of an hair follicle, for all of these are effects sought for by using electrolysis as it really acts upon tissues, expressed above by the qualifying substantives, and if cited by them is indeed the poorest argument, for the fact that the electric current when so applied has this effect of causing condensation, shrinkage, contraction and inflammatory adhesion affords little reasonable ground for expecting to dispel by it an *existing* tubular contraction. Shrinkage does not take place in a peripheral accumulation at the expense of a central attenuation, but just the reverse. Hence, any gain in the calibre of an organic stricture, following such treatment is due to dilatation by the instrument and in direct opposition to the contracting influence of electrolysis.

Wolff has elaborated Newman's theory by resort to the phenomena of kataphoric action and osmose. Seemingly the mucous membrane of the urethra is to act as the porous diaphragm, unaffected itself by contact with the electrode and the products of decomposition. To express his advanced views I must use his own words. After reviewing the action of electrolysis upon fluids, he says: "If employed on the living tissues the same chemical power of decomposition is observed, with which is associated a new factor, namely, the kataphoric; without this, the chemical action of the electrolysis would be of slight value,

since it is only owing to this combined action that the destruction of the volume of the young cells peculiar to neoplasms manifests itself, not only through exosmotic destruction of these cells, but also through a solution of the cell walls in consequence of the caustic alkalies accumulating therein."

He goes on to say: The chemical decomposition alone without the kataphoric effect would be a simple cauterization by alkalies, and this cauterizing effect, could not produce this curative effect, since alkaline caustics were long ago used in such cases without good results, but only favored the return of the stricture by cicatricial tissue formation.

Of all the optimists who urge the advantages of galvanism in the treatment of stricture, no one, it seems to me, has presented the subject in a more practical and reasonable light than Dr. David Prince. He says, when the decomposing agent is used in a moderate degree of intensity the tissues are not at once destroyed but are rendered more yielding, so that, cicatricial tissue; which is ordinarily unyielding, acquires the property of expanding before a moderate force. This happens as the result of what he maintains is a well established fact, namely, that living animal tissues are capable of being softened by the disintegrating influence of hydrogen, so as to offer a diminished resistance to distending forces. In order to get the benefit of this combination, he advises the use of conical sounds and not bulbous instruments, engaging the tip of the sound in the stricture, and having the positive electrode so placed (*i. e.*, under the sacrum), that it will be constantly nearer the point than any other part of the sound.

The same article contains the following: "The galvanic current has another effect, and that is to allay spasmodic action by benumbing nervous sensibility and weakening muscular action. In many cases of moderate stricture the anti-spasmodic element is of great importance in the management of the case. To allay this is to remove one of the difficulties in the treatment by other means."

"It is sometimes found," Prince says, "that though the instrument may fail to pass, the patient finds an improvement in the readiness with which the urine gets away. The relief of the spasmodic element may help to account for this."

Several of Prince's statements corroborate results given in 1872 by Reliquet in an interesting treatise upon the marked benefit to be derived from galvanism in spasms of the bladder, urethra and ureter.

Much that this author asserts has, I believe, a very important bearing upon the cases of genuine cure of stricture by electrolysis. That is, where tight spasmodic strictures have been quite readily overcome and cured by the combined influence of galvanism and dilatation, but where the operator did not recognize the contraction as one of this nature.

One fact mentioned by Reliquet, and verified in my experience, is to the effect that the relief afforded by galvanism in such cases is only temporary unless the exciting cause is removed.

Dr. Hayes has shown more conservatism than any other advocate. Judging from the frankness which characterizes, in an exceptional manner, his article. I believe a little more experience will prompt him to dismiss the idea of benefiting an organic stricture by electrolysis. He says: "When mild currents only are allowed to act, it would seem probable that a gradual breaking up of fibroid tissues can be effected by a combination of chemical decomposition and vital absorption until but a thin lamella of cicatricial tissue remains to mark the seat of stricture. Much and varied observation will be required before this supposition can be substantiated or negatived." The details of his three cases show that the strictures in all were at, or deeper than, five inches.

Although the author makes no allusion to the possibility of inorganic stricture, his account of their behavior and ready yielding to dilatation by ordinary sounds after a single preliminary electrolytic treatment, strongly indicate to my mind that their nature was, in great part at least, of this kind.

I could, in the main, agree if, in this sentence of his, he would accept my insertion of the word spasmodic. "With patience and attention to details, many (spasmodic) strictures can be expeditiously and safely rendered permeable, when, in the absence of this agent (electrolysis) urethrotomy might be required and performed."

I thank Dr. Hayes for his very creditable allusion to one failure. "I was invited to try electrolysis," he says, "with a fourth patient, the subject of an extremely tight stricture, impervious to instruments, and complicated by false passages. This stricture, which was in a measure of traumatic nature, did not yield before the electrode; and I have had no opportunity of learning from the gentleman who has charge of the case whether the smallest benefit resulted from our efforts."

Were others as critical of their work, and had they as keen

an appreciation of truth, I believe many more just such statements would be made.

I regret that this paper was finished when my friend Dr. Burchard kindly sent me the manuscript of his recent article now about to appear in print. His advocacy of the system is satisfactory evidence that there is something about it which deserves recognition, but I must take strong exception to his unqualified approval of the deductions of Belfield and Newman. Did time permit, I would like to review the report of his only two detailed cases, with the purpose of explaining the cures on the basis of my views expressed to-night regarding spasmodic, or the mixed variety of stricture, and try at least to convince him that in accepting the faith of the ultra party he has missed the truth.

My own deductions, regarding my first case, are not at all unlike those of Burchard, where, in concluding his first case he says: "I unhesitatingly declare that the treatment was conducted with less pain and annoyance to the patient and with a better result obtained in a shorter time than I should have expected from the ordinary methods with which I am familiar and am accustomed to employ."

The only indication given by this author of his view respecting the action of electrolysis, is when he says, "The operation aims at producing its results by methods that are purely physiological and not by cauterization or other destructive agencies."

Keyes and Dittel, as well as Newman, have given sufficient evidence, to warrant the dismissal of further discussion as to the unfavorable results of strong currents.

It now remains to consider the negative evidence, in the Newman method. This is not nearly so voluminous as the affirmative; probably for the reason given by one author, who says: "The nature of the question seems not to demand the statistical method. One case carefully observed, if unfavorable, ought to settle the matter." Probably many an one has had this experience and never mentioned it in print.

Marsh says: "We sometimes find it recommended to use a battery, which will secure an electrolytic effect without producing a painful and destructive degree of heat in the living tissues, and that this may be secured by the use of a comparatively mild current. The inevitable law governing the subject is, however, that the electrolytic and thermal effects of the current, other things being equal, are both in the same proportion to the electro-motive force, or strength of the battery. A current which will not evolve heat, will not produce electrolysis." Although

unnecessary, I may quote Scoutellen on this point. "The unquestioned calorific action of the electrical current cannot be separated from the chemical, for, if the heat current be reduced, the power, as well as the chemical effects of the battery is likewise diminished."

Returning to Marsh's article, he says: "The idea that the stricture is melted down in cartilaginous or any other stricture without producing excoriation of the part is a delusion, since the electrolytic action takes place only at the surface of the electrodes, and the effect, when attained, though ever so slowly, must be identical with that of a caustic or red-hot bougie bored through the stricture.

Lest one might infer that Marsh thinks this actually happens let me quote him once more: "No appreciable amount of heat is developed in any metallic electrode imbedded in the living tissue. Even if such were the case the cauterization could be no more destructive or painful than the molecular rending of the part by electrolytic treatment."

The passage of deep stricture, with a mild current, must be due to some other influence, possibly long-continued pressure."

He gives the details of one operation conducted by himself after an original method to determine this point. And, I think, justly adds: "These observations certainly throw some doubt upon the manner in which Belfield states that old cartilaginous strictures in the deep urethra may be opened up by electrolysis."

Berkeley Hill, in discussing the paper of Steavenson and Bruce Clark, says: "The facts related do not lead me to expect that more than a temporary benefit has been afforded, and that was due to the passage of the bougies of increasing sizes which carried the electrode through the stricture; there is no proof that the tissue of the stricture has been absorbed." He details one case in which he operated where the stricture was of such a nature, and so situated, as to permit an operative procedure, which eliminated any reference to dilatation. The result, after several treatments, was a diminution in its calibre of four sizes.

Streeter tried electrolysis in seventeen patients, all of whom had become dissatisfied with dilatation. The calibre of the strictures varied from six to sixteen. The number of applications from six to twelve in each case at intervals of from eight to fourteen days.

He at first used weak currents in all without producing any results, afterwards, in four of these same patients who preferred anything to the knife, he used stronger currents with only bad effects.

All of the cases he afterwards cut with Otis' instrument with immediate benefit, and he believes a permanent cure.

And, finally, I cannot but mention the weighty circumstantial evidence offered by Professor Fenger after the paper and report of cases read by Dr. Belfield.

(*To be continued.*)

# REPORT OF A CASE OF THE MYCOSIS FUNGOÏDE OF ALIBERT.

BY

HENRY WM. BLANC, M.D.

Dermatologist to the Charity Hospital, New Orleans.

THE rare affection of the skin first described by Alibert under the name of Mycosis Fongoïde, and of which he gave an illustration in his atlas more than half a century ago,<sup>1</sup> has of late years been described by a number of observers under a variety of titles. Among the Germans we find the name *granuloma fungoides* to prevail; the French prefer to call it *lymphadémé cutanée*; while the Americans recognize this disease as the *inflammatory fungoid neoplasm* of Duhring. But these names are simply tentative, and even the inventors of them confess that all designations will remain imperfect and unsatisfactory until the true nature of the affection is understood.

Independently of the one here reported, it has been my good fortune to have observed two other cases of this disease within the past four years. One of these was in the service of Prof. Geo. H. Fox, at the Skin and Cancer Hospital, New York; and my position there as House Physician permitted daily observation for several months, during which time the most careful notes were taken. The other case observed by me was under the care of Prof. Stephen Mackenzie at the London Hospital, in the summer of 1886;<sup>2</sup> and I had the satisfaction of having my opinion as to its nature confirmed later on by a number of prominent specialists.

In the clinics and hospitals on the Continent I saw no exam-

<sup>1</sup> Clinique de L'Hôpital Saint-Louis, ou traité complet des Maladies de la peau. Paris, 1833.

<sup>2</sup> Neither of these cases has yet been reported, as far as the author is aware.



ples of this disease ; but the exquisite wax models of M. Baretta at the Hôpital Saint-Louis, Paris, were sufficient to convince me that the two cases just referred to, and the one here reported, are very closely related to those figured by the French dermatologists.

The patient whose disease is now to be described, was admitted into my service at the Charity Hospital on August 10, 1887, with the following history : White man, æt 34 ; native of Germany. Occupation was that of a tailor in New York City previous to 1883. Is of blonde complexion, and was formerly quite fair. While in Mound City, Kansas, in May, 1883, a scaly and itchy eruption, unaccompanied by any discharge, appeared on legs. In about four months this "dry tetter," as he calls it, broke out on the hands also, when rhagades appeared on the palms, and the eruption began to discharge.

It then spread to the breast and arm-pits ; the hands in the meantime becoming so much improved that he could work again at his trade. This he continued to do until the spring of 1884, when there appeared on the body a number of "red blotches covered with yellow pimples which contained a little black spot in the centre." He then entered a hospital in Omaha, where he remained about twenty-one months, suffering with a disease which was called "general eczema," and pronounced non-contagious by the physicians. Patient states that while he was in the Omaha hospital the hair of his scalp, eyebrows, lashes and beard all fell out, but had begun to return before he left the institution in March, 1886.

The eruption disappeared while he was in this hospital, but the skin remained red and tender, and continued to itch over its entire surface. Departing for Quincy, Ill., in June, 1886, he was there able to pursue his vocation until the middle of January, 1887. At this time he had a swelling of the feet which resembled frost-bite, and the toes were cut and cauterized by physicians of the place. Remaining under medical care until April 13, 1887, he then came South by advice, stopping for a time at Hot Springs, Ark., where he took frequent baths which were always followed by chills.

He then came to New Orleans, and under my observation.

#### CONDITION ON ADMISSION.

When admitted to the hospital the patient was very weak, nervous and emaciated, and was compelled to take to his bed. Two facts about him were particularly noticeable : one was the

great number of multiform tumors covering his trunk and extremities, and the other was an extremely disagreeable and pungent odor emanating from his hands and feet.

*Head.*—The skin of the face was slightly thickened, especially about the eyebrows, which were scanty and nibbled off in places as in ringworm of the scalp. The skin was flushed, the nose red, and expression of face nervous and uneasy. Beard straight and growing only from the chin, though, according to his statement, it had been much thicker before he pulled it out when loose from inflammation in the skin. Scalp pale and covered with fine dry scales. The only tumor on head was one the size of a buckshot, just within the meatus of left ear. Tongue and throat normal, but projecting from the hard palate was a purplish tumor the size and shape of a filbert, which had been as large as an English walnut several months before, and seriously interfered with deglutition. On the neck just below chin was one small sessile tumor.

*Trunk.*—The skin of the trunk, considerably pigmented in the abdominal region, was covered indiscriminately with forty distinct tubercles and tumors. While some of these growths were merely hard, purple deposits slightly raised above the skin, others formed sessile or pedunculated tumors that could be caught up between the fingers. The average size of these was that of a split cherry.

*Upper Extremities.*—The skin of the upper extremities was rough, scaly, and slightly pigmented from the irritation of constant rubbing. On the right arm and forearm were twelve tumors distributed over the surface. The majority were about the size of a pea, and projected prominently above the skin; while two or three, a little larger than the rest, projected from eight to twelve lines above the surface as raw, elongated growths, with narrow pedicles, and which secreted an ichorous fluid. The right hand was much swollen, and covered with red, thick skin. In the palm of this hand were three pedunculated tumors the size of a cherry. The fingers were stiff, and could be moved only with pain and difficulty. They were about three times as large as normal, and covered with a fungous mass of a purplish-blue color, soft to the feel, and irregular in shape, being larger at the distal extremities. This outgrowth on the fingers was most marked on the terminal phalanges, where it was heavier and more nodular, obliterating the outline of the digits, which could only be recognized as such by the presence of smooth, clubbed nails, that projected through the mass undisturbed by the disease. The general appearance of the left upper extremity was like that of the right, except that the tumors on the arm and forearm were about sixteen in number, the largest being about the size of a filbert. The left hand closely resembled the right in appearance, except that it was

less swollen, and had the first phalanges of the third and fourth fingers free from disease.

*Lower Extremities.*—The skin of the thighs and legs, particularly the former, was covered with whitish scales and much roughened by rubbing. Innumerable papules, and many prominent tumors the size of a cherry and larger, studded the surface of the thighs and legs. One tumor on the left thigh just below the trochanter of the femur, greatly resembled a door-knob in size and shape.

The most remarkable appearance presented by the disease was seen upon the feet, from the dorsal and plantar surfaces of which projected fungous masses resembling internal hemorrhoids more than anything else, except that they were more of a purple hue. These tumors, when not flattened to the skin by bandages, projected in several instances at least an inch and a half from their attachments, and were very narrow and flat. The toes, though present, could not be distinguished in the mass of fungous growth that projected from the end of the tarsus; though the interlacing nodes could be separated from one another by careful manipulation. The toe nails, unlike those of the fingers, were displaced and deformed, being turned upward towards the dorsal surface of the foot. None of the nails were missing.

The very fetid odor already referred to was due to a seropurulent discharge from the hands and feet, particularly the latter; and originated in the thin membrane-like surface of the fungous masses, which constantly poured it forth without well-defined ulceration. On examination the lymphatic glands were found to be notably enlarged, more especially the axillary, epitrochlear, femoral and inguinal, all of which could be detected with the eye as well as by sense of touch. In addition to these the following could be distinctly felt, and in several cases, seen: the zygomatic, post-cervical, dorsal (just outside of the axillary border of the scapulæ), and the thoracic glands at the lower border of the pectoralis major muscle. Several smooth, red patches on the skin were declared by the patient to be the remains of tumors which had just disappeared, similar processes of resolution having frequently occurred in his history since the frost-bite in January, 1887.

Examination of the internal organs disclosed no special form of disease, and the spleen could not be felt beneath the abdominal walls. The patient was in a very nervous condition, jumping if any of the tumors were touched, and complained of intense itching, particularly at night, in consequence of which he kept up a continual rubbing of the skin at all times. The appetite was poor and bowels moderately regular. Urine examined chemically and microscopically, and nothing abnormal found. Specific gravity: 1010.

Such was the case as at first came under my observation. Recognizing in it a rare disease, and believing it to be similar to the two cases already referred to, I determined to administer iron and arsenic with the idea of increasing the blood-cells and improving the nutrition of the skin. Being about to leave the city on a six weeks' vacation, I ordered the following mixture, to be continued, if practicable, until my return:

℞ Ferri et Quinæ Citrat., 3 ii; Liq. Potass. Arsenit., 3 i; Syr. Aurant. Cort., 3 i; aquæ, q. s. ad 3 ij. m. et S. Dessert spoonful three times a day after meals. This was administered in my absence, and no other directions given, except for a powder of ten grains of hydronaphthol with half an ounce of bismuth to be applied to the discharging surfaces on feet and hands. This powder did good service, and greatly diminished the fetid odor.

During my absence small specimens were cut from the tumor of the foot and sent to the pathologist, Dr. Schmidt, with the request that they be examined for the bacillus lepræ. The report showed, as might have been anticipated, that not only were there no bacilli, but that the neoplasm did not in the least resemble deposits of leprosy. On my return, frequent notes were made of the case, and I shall endeavor to give those that best show the progress of the disease.

#### CLINICAL HISTORY.

*November 15th.*—Patient has been taking arsenic and iron for three months, and shows decided improvement in skin lesions. The tumor in mouth has diminished to the size of a pea, that on thigh is now the size of a hazel-nut, and several small ones on the arms and legs have disappeared altogether, leaving no cicatrices, and very slight pigmentation. Hands are less swollen, and have lost their raw appearance; feet discharge less, and are not as tender. Ordered ichthyol (sulpho-ichthyolate of ammonium) and vaseline, equal parts, to be applied constantly to fingers and hands.

*November 25th.*—Thickening of fingers have notably diminished under use of ichthyol. On removing a tumor for microscopical examination great nervousness was produced, followed by a chill and slight elevation of temperature, after which patient perspired freely. These nervous chills have occurred several times of late, particularly after a handling of the tumors or stripping of the patient for examination. The temperature seldom rises higher than 100 degrees during what he calls his "fever attacks," though he perspires profusely after them, the face remaining redder for two or three days at a time. Says he has sensations similar to these, but milder, after the feet are dressed in the evening. The fever is easily controlled by cinchonida. Intense itching is a constant symptom.

*December 12th.* Had one of his nervous attacks, followed by sweating and great prostration, after being removed to another part of hospital to be photographed. Hands are looking well, but feet have been painful of late. Substitute the following for the hydronaphthol mixture on feet. Iodoformi, Bismuth. subnitrat., aa  $\text{ʒ i. m.}$

*January 16th.* Tumors on the trunk have decreased to ten in number; and those on extremities had ceased to grow until two weeks ago, when diarrhœa set in, and arsenic mixture was temporarily stopped in favor of opium and bismuth internally. Several tumors have rapidly increased in size and taken on a fungoid appearance since discontinuance of the arsenic. But bowels have improved, and arsenic is now resumed with twenty grains of subnitrate of bismuth at a dose. As the feet are better, it is determined to try the effects of ichthyol in place of the powder of Dec. 12th, though this has given great relief: Ichthyol.,  $\text{ʒ ss}$ ; Iodoform.,  $\text{ʒ jss}$ ; Vaseline., q. s. ad  $\text{ʒ ij. m.}$

*January 27th.* Feet are swollen, and ichthyol discontinued in favor of hydronaphthol powder, which has been most successful in drying and deodorizing the surfaces. Face remains flushed now, but tip of nose is less red. Tumor in mouth has entirely disappeared, and nothing remains but a dark spot the size of a pea, which is flat, and level with surface. Tumor on thigh near the trochanter is gone, and nothing remains to mark its former site. For the first time it is noted that the thyroid gland is slightly enlarged.

*February 8th.* Had herpes facialis last week, most marked about the corners of the mouth, but it is now fading rapidly. Says he has had herpetic eruptions on face several times during the past two years. Arsenic, iron and bismuth administered regularly.

*February 9th.* No nervous paroxysms lately, and has been walking about the ward. Hair of scalp is thinning from constant scratching, and the skin of scalp is redder than formerly. The back, between the shoulders, and the chest at root of neck, are scaly from scratching. Abdomen less dark than formerly. All the tumors have disappeared from the trunk except one just above the left nipple, one three inches to the left of right nipple, and one in right axilla, making a reduction from forty to four in six months. The largest tumor now on the trunk is not larger than a split cherry. No cicatrices have been left and only three tumors are followed by pigmentation. For the intense itching patient has used strong ointments of carbolic acid before coming under my care, and without good results; so a salve containing a drachm of dilute hydrocyanic acid and an ounce of vaseline is ordered, with the hope of diminishing friction. Bismuth discontinued.

*February 28th.*—Walking causes feet to swell, so horizontal

position is ordered. Bowels have been loose again, and patient has been taking only bismuth for past week ; and to-day three drops of Fowler's solution are added to the dose. Many tumors on the extremities have increased in size. It seems that whenever the arsenic is stopped the tumors begin to grow, and discharge more profusely. It is also a queer fact, first noticed by the patient himself, that whenever single tumors enlarge and discharge, the smaller ones in their vicinity diminish or disappear.

*March 1st.*—Has had two bloody stools, accompanied by an odor similar to that of the feet, and very offensive. Rectum feels very sore. The small toe of left foot is ulcerating and quite painful, so a mixture of iodoform, bismuth and starch is applied. General health remains about the same. Bowels have been moving twice a week.

*March 10th.*—The aspect of the extremities has changed a great deal, four new tumors have come and old ones disappeared. In the evolution of these growths there is never any loss of tissue. The smaller ones disappear by absorption, leaving a bluish-red mark level with the skin. This, in turn, disappears, leaving a temporary pigmentation. The larger growths usually become moist and raw in appearance, discharge an ichorous pus for a while, then become dry, contract and disappear. In accomplishing this last process it is not uncommon to see a long tumor with narrow neck contract to a spheroidal shape, and rest in a sort of crater of raised skin. Attached to the centre of this crater by a narrow pedicle, it rests there like a ball in a socket, and can easily, though not without producing pain, be detached from its cup. The right arm and forearm now present five tumors for inspection, the largest of which is the size of a pecan-nut ; while on the left arm and forearm are seen fourteen of these growths, the largest of which is the size of a split cherry. There are no tumors on the back of the hands, and only two or three indurated spots indicate the site of former tumors of the palms. None of the first phalanges are diseased, and the first two fingers of the left hand are unaffected. Flexion of the fingers is performed now with ease, and the deep-red color of former disease now exists only at the edges of the nails. Both hands are swollen, but the left is better than the right. Seven tumors can be counted on the left lower limb near or about the knee, and ten on the right in the same locality. These are irregularly distributed above and below the joint, being for the most part on its lateral borders. They are larger than those of the upper extremity, several being the size of pecan-nuts, only somewhat flatter. They are not unlike hemorrhoids in appearance.

Pigmentation and roughness of thighs and upper half of legs remains as before. Toes are smaller and have lost the appear-

ance of a continuous mass of tissue, and their divisions can be distinctly seen. Feet are swollen and cedematous, and have no tumors on dorsal surfaces. Not so with the lateral and plantar surfaces, for the right foot presents six moist, tender, pedunculated tumors, about the size of a large cherry, growing from its outer side. Under both feet are numerous prominent and slightly pedunculated tumors, which are largest at the heels, and prevent the patient from taking his wonted exercise about the ward. Hydrocyanic acid salve is still used to lubricate the skin, though its effect on the pruritus is very slight.

*March 18th.*—Bismuth to be omitted as bowels have not worked for six days. Has not taken iron for one month. Resumes to-day the iron and arsenic mixture, taking five drops of the Fowler's solution at a dose. Fingers are swollen, and ichthyol replaced by iodoform salve.

*April 5th.*—A swelling the size of a hen's egg divided in half longitudinally, has been present several days on the left arm just in front of and above the enlarged epitrochlear gland. It is very tender to the touch, and gives pain; but the skin above it is not inflamed. Corresponding to this on the right arm is a tender nodule which has been present only a few hours. Patient states that he had a number of similar painful spots with swelling along the course of the saphenous vein in the thigh about a year ago, and confidently asserts that these will soon pass away, as did the others.

*April 11th.*—No new tumors have appeared, and all old ones are smaller except a fungoid growth the size of a walnut on the left arm. The trunk and thighs are covered with a smooth, reddish, indistinct, macular eruption, resembling secondary syphilitic manifestations. These macules are about the size of a silver dime, or smaller. Bowels have been loose again, but have been checked with bismuth. Rectum and anus are tender, but no new growths are found. Swelling and tenderness of arms above the elbow have greatly diminished. Complains of a burning sensation in meatus urinarius when he passes water. The glans penis, though not swollen, is red and tender, and the meatus a little puffed, as in acute gonorrhœa. Urine remains normal, the specific gravity being 1019.

*April 28th.*—A careful examination to-day discloses the following: Condition of face just as formerly, only the skin is thicker and more permanently red. The macules on the trunk are not so numerous; but the skin remains pigmented. There are many excoriations produced by scratching. *Not a single tumor can be found upon the trunk.* On the right arm are counted three tumors, all about the size of a pea. On the left arm are likewise three tumors, two of which are the size of a pea; while the third is the size and shape of a silver dollar, only twice as thick, and attached to the skin by a short pedicle

which passes to its centre, and has the thickness of a lead-pencil. The tender new-growths just above the elbows give no more pain, and are now the size of the enlarged epitrochlear glands already noted. These are now regarded as lymphatic glands which were formerly too small to be felt, but which have enlarged with irritation. Both forearms remain pigmented and rough; on the left are two small tumors; the right is free from them. Both hands are somewhat œdematous and swollen,—and the left more so than the right. There is a decided improvement in the hands, though the thickened skin remains; and small, fungous swellings are still found on the thumbs and little finger, more particularly on the left hand, which was the better of the two some six months ago. Projecting from the gluteo-femoral sulcus on the right side, is a tumor the size of a large chestnut. This is dry and in a process of resolution, as are also two pea-sized tumors on the right thigh. The prominent tumors noted upon the knees a month ago have diminished in size and number, for the right knee has but three small nodes, while the left has two pedunculated tumors size of a filbert, projecting from the prominences made by the head of the fibula and internal tuberosity of the tibia. Both legs are œdematous, shiny, and red, but not painful; and on them can be found but one tumor. This is the size of a pea, and situated in the lower half of left leg. It is now recalled that, several months ago, a large discharging tumor which was just above the right ankle, and which gave considerable discomfort, has disappeared, leaving nothing but a slight redness of the skin. The feet, though never as well as now, still show the worst phase of the disease. The tumors occur about the prominences only, though the skin of the instep above and below is red and tender. The toes of both feet are equally affected, and can now be moved separately by the patient. The right heel is in good order, but attached to the left are five fungoid masses, each about the size of a filbert, discharging a watery fluid. The adenopathies remain about the same.

## REMARKS.

Such is the clinical history of this interesting case during a period of eight months. It would be interesting to compare it with other cases which do not exactly conform to the characters of the fungoid mycosis of Alibert, reported by Tilbury Fox<sup>1</sup>, Van Harlingen<sup>2</sup>, Hardaway<sup>3</sup>, and Hyde<sup>4</sup>, and with which

<sup>1</sup> Fibroma fungoides. *Skin Diseases*, 2d Amer. ed. New York, 1873.

<sup>2</sup> Ulcerative scrofuloderm. *Arch. of Derm.*, April, 1879.

<sup>3</sup> Multiple tumors of the Skin, accompanied by intense pruritus. *Arch. of Derm.*, April, 1880.

<sup>4</sup> Myeloma cutis. *Diseases of the Skin*, 1883. The author has just received the 2d ed. of Dr. Hyde's work, in which he refers to the same case as one of mycosis fungoides.



cases the one here recorded has many symptoms in common. But space forbids. When the man came under observation he was weak and emaciated, and though he cannot be fairly said to have gained in weight, he has not lost, and if not stronger, he is no weaker now than then. That arsenic has been useful in the treatment I do not doubt, for the tumors have become worse whenever this was discontinued, even for brief periods. On the other hand we find that the patient has taken this medicine with few intermissions for eight months, and during this period the tumors have all diminished in size, while many have disappeared entirely. As the notes show, iron was frequently combined with the arsenic, and has doubtless proved itself useful. We know also that ichthyol was useful as a local application, for it was continued on the hands, and there only, often when the arsenic was stopped; and while new tumors appeared elsewhere the hands steadily improved. The persistent pruritus remains unabated, and it is possible that the arsenic may have aggravated it, or at least impeded its improvement. It will be noticed that the nervous paroxysms and fevers referred to in early notes, gradually ceased, and that the patient has not been harassed with them for some time.

*(To be continued.)*

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#### GENITO-URINARY NOTES.

BY

GEORGE E. BREWER.

Clinical Assistant in Genito-Urinary Diseases, College of Physicians and Surgeons,  
New York.

**I**N reviewing the histories of about 1,000 recorded cases of genito-urinary disease, treated by me during the past two years, the following notes regarding the success attending various methods of treating some of the mere ordinary conditions have been gathered:

##### THE USE OF BICHLORIDE OF MERCURY IN GONORRHOEA.

In a paper read before the New York Dermatological Society on March 22, 1887, entitled, "Some Observations Upon the Modern Treatment of Urethritis," I called attention to the use of mild solutions of bichloride in the urethra by continuous irrigation and hot retrojection. These two methods, first suggested by Drs. W. S. Halsted and H. Holbrook Curtis, were described at length, and the results in about 150 cases recorded.

In the acute cases the distinction was made between the specific or gonorrhœa form of urethritis and the non-specific or simple variety, and in each of these classes, as well as in chronic cases, the success of treatment was noted. At the close of the paper the following conclusions were drawn:

*First.*—That in uncomplicated cases of acute gonorrhœa urethritis, treated by prolonged and frequent irrigation with bichloride of mercury, recovery may be expected within two weeks. That this period may be considerably shortened by the early inauguration of treatment, by absolute rest, and by the avoidance of stimulants. That it may be indefinitely prolonged by irregularity in treatment, by inordinate physical exertion, and by indulgence in alcoholic and venereal excesses.

*Second.*—That the retrojection of a hot solution of bichloride possesses all the advantages of the former procedure, and in addition causes a more rapid subsidence of the inflammatory symptoms, a greater feeling of comfort to the patient, and is attended with less annoyance and trouble.

*Third.*—That in cases of acute non-specific urethritis the favorable influence of each of these methods is strikingly apparent.

*Fourth.*—That in cases of chronic purulent urethritis, no agent produces such rapid and permanent improvement as irrigation, especially when combined with astringents and heat.

*Fifth.*—That the percentage of complications occurring in cases treated by these methods is far below that observed when the ordinary treatment is employed.

Since the reading of that paper, I have recorded 102 additional cases of urethritis treated by these methods. Without entering into a careful analysis of these (that being reserved for another occasion), I will briefly state that the results obtained were more satisfactory than at first, and fully justify the conclusions with which I closed my first paper.

In my first series of cases, the average duration of treatment to the cessation of all discharge was seventeen and a half days, while in my last series this was reduced to thirteen days.

Every case, favorable or unfavorable, in which the result was known, has been included in these tables, and I believe they represent a fair average of what may reasonably be expected by a faithful use of this treatment in uncomplicated cases.

Inflammatory complications, occurring during this treatment, are rare. I have had but five in over 250 cases, or about

two per cent. Of these, three were cases of epididymitis, one of cystitis and one of prostatitis ; while in 352 cases treated by other methods, epididymitis alone occurred in sixteen per cent. of the patients.

Hot retrojection has proved a most valuable procedure in the treatment of chronic urethral discharges. Eight cases, in which the discharge had persisted for several months, were relieved after one treatment.

Cases are occasionally encountered, however, which will not yield to these methods. In all such the urethra is found to be the seat of one or more strictures, which render its walls rigid and inelastic, thereby preventing the free circulation of the fluid within its cavity.

#### THE USE OF THALLIN IN GONORRHOEA.

A number of experiments, to test the value of sulphate of thallin, were undertaken—uncomplicated cases of acute specific urethritis were chosen. In some, injections of a two per cent. solution were employed, in others it was used by means of soluble bougies. No benefit whatever followed its use by injection. The thallin bougies seemed in some cases to lessen the amount of discharge to a very considerable extent. This, however, was not permanent, as the discharge would reappear whenever the bougies were omitted, even after their long-continued use. During their employment, moreover, the *ardor urinæ* was greatly increased, and frequency in micturition occurred in nearly one-half of the cases.

The partial success of thallin employed in the form of soluble bougies led me to attempt the use of bichloride of mercury in the same manner. A number of bougies containing this agent in the proportion of 1-10,000 and 1-20,000, were kindly furnished me by one of the manufacturers. In all cases so treated, there occurred a marked diminution in the amount of discharge, but the pain attending their use was so severe, and the vesical irritation so great, that their employment was abandoned.

Experiments were also made by injections with sub-iodide of bismuth suspended in glycerine and water ; with nitrate of silver two grains to a pint of lime water ; with strong solutions of bicarbonate of sodium ; with zinc sulphate and zinc acetate. No apparent benefit followed the use of these agents in acute specific cases, although their value in non-specific and chronic cases was often strikingly apparent.

Internal treatment alone was employed in about fifty cases. Large doses of potassium acetate sufficient to render the urine markedly alkaline, aside from allaying the pain on urination, produced no noticeable effect upon the course of the disease. Powdered cubebs in doses of one teaspoonful every two or three hours would usually succeed in checking a urethral discharge within twenty-four hours. The use of this drug, however, was continued in several cases for many weeks, without producing any permanent result; the discharge reappearing whenever the medicine was omitted.

The La Fayette mixture was employed in thirty-two cases. In five only of these was recovery known to have taken place—the others were still unrelieved when last seen. The average duration of treatment in the five cases that recovered, was forty-one days.

#### THE PAQUELIN CAUTERY IN ACUTE EPIDIDYMITIS.

The use of the actual cautery in acute epididymitis was first suggested by Dr. W. S. Halsted. His method consists in lightly touching the surface of the skin overlying the affected organ, with a white-hot cautery point. The operation requires only a few seconds, and if skillfully performed is but moderately painful. A dressing of iodoform ointment is then applied and the patient instructed to wear a suspensory bandage. Instant relief from pain almost invariably follows the application of this treatment, and the patient, as a rule, is able to be up and walk about in comparative comfort.

I have treated forty-six cases by this method, and in only two instances have the patients been obliged to remain in bed after the first application, and in one of these the real cause of the enforced rest was a co-existing cystitis.

It may be added in this connection that marked relief from pain in gonorrhœal rheumatism may also be effected by a similar use of the cautery and iodoform ointment, and this combined with absolute rest has in my experience proved the most satisfactory method of managing this obstinate class of cases.

Another method of applying strong counter-irritation in acute epididymitis is by means of a sixty-grain solution of nitrate of silver applied to the surface of the scrotum. I have employed this in thirteen cases, often with marked success. It, however, has the disadvantage of frequently causing a slough of the epidermis, leaving often an extensive patch of superficial ulceration.

## TREATMENT OF CHANCROID.

The most satisfactory treatment for chancroid which I have employed is thorough cauterization with pure nitric acid and the subsequent application of salicylic acid powder,—the object being, first to convert the infected ulcer into a healthy one, and then to prevent reinfection of the wound. While this method succeeds admirably among the better class of patients, it often fails completely in hospital practice from a failure to carry out the after treatment. I have frequently seen reinfection take place in ulcers that have been perfectly healthy for several days, by simple contact with clothing upon which the dried secretions from the original sore had been allowed to remain.

A method, which in my hands has proved valuable in this class of cases, but which, as will be seen, is applicable only to chancroids occurring behind the corona glandis, is the following:

The organ is cleansed with a strong solution of bichloride,—all ulcerated points thoroughly destroyed with nitric acid. Salicylic acid powder is then heaped upon the wound and covered by a strip of thin rubber protective which completely encircles the penis. This should be snugly applied and held in place by a few layers of absorbent gauze and a small bandage. The heat and moisture of the body soon cause the thin rubber tissue to adhere closely to the skin, completely sealing the wound; its elasticity, also, allows of considerable change in the size of the penis without disturbance. This dressing should be left in place for from three to six days, and completely protects against reinfection. If properly applied the resulting ulcer is always healthy and closes rapidly. I have applied this method in ten cases with most satisfactory results, in several of which very extensive ulceration was present.

It was my original intention to give the results of some observations upon the treatment of gleet, stricture and cystitis, but as I have already more than filled my allotted space, I must reserve that for another occasion.

118 MADISON AVENUE.

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**Correspondence.**

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**DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.****Prophylaxis of Syphilis.**

Two of the medical societies of Paris have at some length recently discussed the important and hitherto insoluble problem of the prophylaxis of syphilis. At the Academy of Medicine, thanks to the impulse given to the

subject by the chairman of the commission, Professor Fournier, the debate became quite a lengthy one. The conclusions adopted are sub-divided into four paragraphs. In the first, relative to the administrative prophylaxis, the Academy calls attention of the authorities to the increase of late, of solicitations upon the streets and in public places, and calls for its energetic suppression. It is believed that there is a manifest necessity of including in this solicitation on the street, that mode which is not less dangerous to public welfare, namely, that of the shops, that of drinking places where women are in attendance, and more particularly still, that of the wine rooms in which the waiter girls and attendants solicit the patrons and pass with them into the back rooms. The Academy points out to the authorities in a no less special manner, the condition of affairs in the neighborhood of lycées and colleges, which result in encouraging habits of vice in minors and lead to debauch. It is demanded that a sanitary police law regulate and strengthen as quickly as possible the administrative interference, particularly regarding minors, which will permit provocation to be stamped out wherever it may appear. All women given up to prostitution should, so far as possible, be subject to registration and sanitary visits. If this registration is not submitted to willingly by those women upon whom the authorities would impose it, then it should be ordered only by judiciary authority.

All women found upon examination to be suffering from venereal disease, should be confined in a special establishment, which would be only a hospital from which they could not go out until cured of all transmissible lesions. This last recommendation has a great importance. We must admit that for many years, and still at the present moment, women who are registered and known to be sick are incarcerated in the St. Lazare prison, in a special department it is true, but still in the same establishment having the same food and the same discipline of prison life as ordinary criminals. This state of affairs is a shame to Paris and should no longer exist. The recommendation calls for the complete abolition of the St. Lazare as a hospital for venereal cases, and we can only heartily approve of the decision of the Academy.

In the second paragraph relating to the hospital confinement and treatment of venereal cases, the Academy submits that the number of beds given up to venereal cases in France, and especially in Paris, is altogether insufficient. The number should be increased by the creation of new special hospitals. The remedies necessary for the treatment of these diseases are to be given gratuitously in all the hospitals both special and general.

A service of free consultation and free medicines should be added to the special sanitary institution destined for the treatment of venereal prostitutes.

In the third paragraph relative to reform to be instituted in medical education and instruction, the Academy asks that all venereal services for women as well as for men be open for free instruction (comprising those of St. Lazare which till now have been rigorously closed, being regulated by prison discipline) to all properly qualified medical students. It is much to be desired that all future physicians should have had a venereal service. All the medical staffs in charge of both male and female venereal services should be chosen by competitive examination.

In the fourth and last paragraph relating to the prophylaxis of syphilis in the army and navy, the Academy asks that the rigorous execution of military regulations, and especially those relating to sanitary visits be carried out.

Searching out hot-beds of contagion, giving up all military discipline in the case of affected soldiers or sailors, instructing the men in the dangers of clandestine prostitution, and facilitating after treatment in those cases in which treatment was begun in hospital, are all means of accomplishing this object. The Society of Practical Medicine has been struck, as well as the Academy, with the incessant advances made by clandestine prostitution, but the conclusions arrived at in regard to it are somewhat different. Attention is called, and we believe with much good reason, to the fact that the number of registered prostitutes diminishes from day to day, that the situation in which they are placed is so intolerable that many of them disappear rather than submit to the obligations resulting from registration; that it is among the young women not yet of age that a relatively large number of cases of syphilis is found; that the time of treatment at the prison infirmary of the St. Lazare is too short; that men are the agents of contamination, that the law does not authorize the arrest of prostitutes; that syphilis is a disease and not a crime, and that the affected woman has actually incentives to hide her disease rather than to acknowledge it. Therefore, the society after receiving a report from Dr. Lutaud, and a remarkable work of Dr. Nallcot has approved the following recommendations:

1. To create numerous dispensaries of public health for venereal diseases and offer every means of treatment to those requiring it.
2. To make prostitutes amenable to the common law in suppressing arbitrary imprisonments and forced visits.
3. To maintain the liberty of each individual upon the public streets by legal means.

Certainly all these efforts more or less liberal to diminish clandestine prostitution are most honorable, but permit us to say that we are greatly in doubt regarding their efficacy. We must applaud the efforts at any rate, for it seems to us that they should at least bring about the suppression of the St. Lazare as it now exists, at the same time a prison and a venereal hospital which is an anachronism not longer to be tolerated in a city like Paris pretending to march at the head of civilization.

#### Treatment of Lupus Vulgaris.

In my preceding letters I have told you of the principal methods of treating lupus as employed in France and in particular of the quadrilateral linear scarifications of Vidal and the actual cautery of Besnier; cauterization which can be made with the thermocautery or more especially with the galvanocautery. For a number of years I have undertaken to combine these two procedures, and I have thought to thus obtain excellent results. I call this the *mixed method*. This is how I carry it out.

When we have a lupus to deal with from the first, which is superficial, and on the person of a vigorous subject, if the lupus occupies parts exposed to view, we must scarify it, then wash it with Van Swieten's solution and dress it with compresses wet with the same or with Vigo plaster.

Thus is obtained, quite rapidly, a complete cure without the least apparent cicatrix. If, however, a few nodules of lupus persist with some tenacity we can apply with great advantage once or oftener the fine point of a galvanocautery, and end the treatment with a few sittings of scarification to make a good cicatrix.

When we have a lupus vulgaris to combat which has existed for some

time, the employment of scarification or of the actual cautery depends upon a number of accessory conditions. If the subject is not very healthy, if his condition raises doubts as to the integrity of his lungs we must resort first of all to cauterization and employ it as long as possible. Scarification is here to be resorted to only late in the treatment to improve the cicatrix. If the subject, although healthy, has an exuberant, turgid, extensive, hypertrophic lupus there is advantage in beginning with the cautery, either using fine points or the galvanocautistic grill to reduce, efface, or reduce in a measure the new growth. But the red iron must not be continued with too long, and especially must we not cauterize too deeply. We must study with the greatest care the aspect that the cicatrix will take, for many patients have a deplorable tendency to keloid formation after actual cautery at all extensive. I think, therefore, that as soon as we have sufficiently reduced the lupus plaque we should resort to several sittings of scarification to render supple and make a good cicatrix. We then renew the cautery as it has proven beneficial. If a few rebellious tubercles remain in the healthy tissues a few extra seances of scarification will give an excellent result so far as cicatrix is concerned. It must not be thought that scarification alternating with the cautery extend the length of time of treatment necessary in a given case. From my observations I am persuaded to the contrary. I wrote in 1886 that when we treated lupus by scarifications we must resort to cauterization as soon as evidences of the useful effect of scarifications were no longer noticed and vice versa.

I am more and more convinced of this therapeutic precept. In changing method a number of times in the treatment of a lupus as I have recommended, we reach a cure much more rapidly than when we strive to employ but one. By the preceding combination we obtain much more beautiful cicatrices than with the hot iron alone, and this much more rapidly than when scarifications are alone employed. We should not, however, reject systematically the other methods which are well known in the treatment of lupus. There are cases in which very rapid benefit is obtained from tearing open the isolated tubercles and then cauterizing them with a pointed stick of nitrate of silver.

The scarified or cauterized surfaces should be dressed according to the nature of the case, either with cataplasms wet with a solution of boric acid or corrosive sublimate, with Vigo plaster, with iodoform or with the subcarbonate of iron. I use with a certain amount of success ointments, collodia, and plasters of salicylic acid, and of pyrogallie acid when patients are forced for one reason or another to interrupt their surgical treatment. I believe that when we have begun to treat a lupus we should never leave it a single instant without some treatment until complete cure. It is not the less true that in spite of all the attempts that have been made to treat lupus by parasitocides, the two great methods, par excellence, and which always give good results are quadrilateral linear scarifications and the actual cautery. I will add that there is all advantage in combining these two powerful means of action according to the circumstances of the case.

#### **Destruction of Hairs by Electrolysis.**

In a communication which I have recently made to the Medical Society of the Paris Hospitals, I gave the results of my quite extensive experience of the past two years in regard to the destruction of hairs by electrolysis.



I have already operated by this method on about thirty cases, and of these I have observed twenty long enough to publish the observations.

The results obtained have been satisfactory in nearly all the cases, excepting in my first case, where, striving to go too fast, I obtained vicious cicatrices. I have, however, been able, by combining electrolysis, linear scarifications and Vigo plaster, to make them disappear and restore to the integument all its suppleness. Here is a short resumé of my work : I begin by calling attention to the fact that it is not to Dr. Michel, of St. Louis, in the United States, that the honor is due of having first had the idea of employing electrolysis for the destruction of hairs in trichiasis, but to Prof. Léon le Fort, of Paris, who as early as 1877, in the *Manuel of Operative Medicine* of Malgaigne (8th edition, 2d vol., page 38), advises this procedure. The majority of the women whom I have treated have borne the pain which the operation occasions very well. However, in certain cases I have caused insensibility of the part where there was too much pain, such as the upper lip or the suprahyoid region, by a subcutaneous injection of the hydrochlorate of cocaine. I employ as positive pole a metallic handle covered with chamois skin wet with a saline solution, and this the patient holds pressed in the palm of the hand. I think this mode of procedure more agreeable than that of fixing a conduction plate upon some region of the body. The patient is thus enabled to interrupt the current at will, and one can operate if necessary without an assistant and without being obliged himself to turn the collector of the electric apparatus, and without causing too great suffering. In my first writings upon this subject I advised that an assistant be present, and as soon as the needle was in the hair follicle he turn on the current slowly and gradually, stopping as soon as the needle of the galvanometer pointed to the number of milliamperes with which it was desired to operate. When no assistant is at hand one is obliged to turn on the collector himself, which is very embarrassing, or else to place at once the collector at the number of elements corresponding to the current which it is intended to use, and if the positive pole is already fixed at some point on the body's surface, it is the extremity of the needle which closes the current. As soon as the point of the needle comes in contact with the skin the current passes. Now, it is very difficult to penetrate at once into the hair follicle without feeling a little the way. These little pricks and the sudden passage of the current in all its strength are very painful, it is not at all the same thing when the patient can at his own free will release or seize the cylinder constituting the positive pole. The operator begins, then, by introducing his needle into the hair follicle, and when it is well placed he tells the patient to press the cylinder. This is done slowly but progressively until it is pressed with the whole hand. When the hair is judged sufficiently destroyed he is told to release the cylinder and the needle is withdrawn. The pain is modified, although still more sudden and acute than when an assistant manages the current. The needle which I ordinarily use is one of platinum composed of three parts—1° of a metallic cylinder one and a half centimeters long and three or four millimeters in diameter, divided into longitudinal facets, so that it can be held quite firmly in the hand, rolled between the fingers and turned readily in all directions ; 2° of a fine cylindrical rod two centimetres long ; and 3° of a terminal part six or seven millimetres long, as fine as possible, and separated from the cylindrical rod by a circular metallic collar. I find it preferable not to use a needle-holder. This instru-

ment tires the hand and makes it less easy to note the various sensations of resistance of the tissues, which are the guides to the introduction of the needle. There are few hairs which require a very short instrument. How, for instance, can we manœuvre an ordinary needle-holder when we have hairs in the supra hyosid region to destroy which grow obliquely?

To save the superior layers of the skin and only act upon the hair bulb, I have had made another needle called an isolated needle, constituted by a platinum stem of the same length and size of the preceding needles and mounted upon the same cylinder. Two millimeters from the point which is made as fine as possible a slight groove is worn in the stem and into this groove an extremely fine silk thread is wound so as to completely cover the metal and act as an isolating body. This needle presents most of the requisite qualities. The isolating body protects sufficiently the tissues, at least during the destruction of the first fifteen or twenty hairs, for after this it becomes impregnated with foam and detritus and becomes in a measure a conductor. When it is well placed, however, it resists for some time quite well and not project to impede the introduction of the needle, into the follicle. However we must be aware that this introduction is not so easy as with the ordinary needle. We are often obliged to make some circular movements in order to introduce the isolated needle, but this is easy, thanks to the ribbed nature of the cylinder which can be rolled between the index finger and thumb. The use of this needle presents two other difficulties: 1st, it is quite difficult to know if the free end of the needle is exactly in contact with the bulb of the hair; 2d, we can scarcely know when we use it, the exact moment at which the bulb is destroyed or when we should cease passing the current. We must decide to feel our way and to use a current of known strength for a well determined and rigorously carried out length of time. This time will be such as experience has shown to be necessary, and sufficient in the case under treatment. I believe that we should reserve the isolated needle for the cases in which we have only a few large hairs situated in a well exposed location, for with them we are sure of leaving not the least trace of the operation. There is absolute necessity of introducing the needle within the hair bulb along the course of the hair, and not into the skin alongside of the hair. The needle should penetrate without resistance to the desired depth; this varies according to the situation of the bulbs and consequently varies with the individual and the region. I only use currents varying in intensity from two to five milliamperes. Two hairs close together should never be destroyed at once for the resulting vesicles which follow the operation at the points touched would join and become confluent. If this lesion is produced we may be almost assured that vicious scars will follow, white spots, and depressions and even veritable keloids in those predisposed. It is difficult to know the exact number of hairs which grow again after the operation; I do not think there have been more than one recurrence out of six in my cases. In a young girl who had a tuft of hair upon the chest only two grew again after 200 were destroyed. Still I think that electrolysis causes the fine hairs of the regions frequently operated to grow stronger and that it facilitates their transformation into adult hairs. When all the large hairs of a given region which were visible at the commencement of treatment have been destroyed by electrolysis, we are far from having ended our task, at least, in the majority of cases. We see indeed the points operated become covered with regular hairs, but fewer than those removed, and having large

pulpy roots deeply imbedded. These are not primitive hairs which have been incompletely removed, but hairs newly developed which it is necessary to remove to obtain a lasting cure, and we should deem ourselves fortunate if other new hairs do not succeed this second growth. I think then considering the length of time required and the possible inconveniences of electrolysis even when it is done under the most favorable conditions, it should only be employed when absolutely necessary. It should be employed at once when we have to deal with a few large hairs scattered here and there upon the face or upon the breast. But where there is an abundance of lanugo which might become transformed into hairs we should only proceed with the greatest prudence. However it is well to know that the radical destruction of hairs by this process is now an accomplished fact and that we can always bring about complete cure with the exercise of sufficient energy and perseverance.

L. BROCCQ.

PARIS.

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## Book Review.

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**THE SURGICAL DISEASES OF THE GENITO-URINARY ORGANS, INCLUDING SYPHILIS.** By E. L. Keyes, A.M., M.D., etc. A Revision of Van Buren and Keyes's Text-book upon the same subjects. New York : D. Appleton & Company. 1888.

THE original work under the conjoint authorship of Van Buren and Keyes upon which the work before us is founded and whose general plan and scope is here preserved was entitled "A practical treatise on the surgical diseases of the genito-urinary organs, including syphilis, with engravings and cases." Fourteen years ago when this earlier treatise was published there was perhaps sufficient justification for comprising in a single book topics so dissimilar as syphilis and surgical diseases of the genito-urinary organs. By custom or convenience, they had come to be regarded as properly within the ken of a single specialty, and concerning both of them the distinguished authors were in a preëminent degree competent to speak. Yet between syphilis and genito-urinary diseases there is really little in common. In the study of each during the past decade, the developments have been immense and wholly independent of each other. While on both of these divergent lines of progress the zealous industry and eminent acquirements of the author of the present work have enabled him to maintain advanced positions, it cannot be said that the medical public at large has any corresponding interest in associating together these diverse departments of study. Formerly eye diseases were invariably associated with diseases of the ear, venereal with skin diseases, the infectious exanthemata with dermatology, and syphilis with surgery, much as the profession of barber was associated with the practice of venesection. But with the progress in medical science these illogical associations are constantly being broken up, and special departments of study are formed more in harmony with a legitimate system of scientific classification. The general criticism here made is especially suggested in the present case by the form of the title which Dr. Keyes has adopted. It is not felicitous. It would imply that syphilis is one of the surgical diseases of the genito-urinary organs. "A practical treatise" on any subject may in-

clude syphilis or anything else, but syphilis cannot be said to be included among genito-urinary diseases and least of all surgical diseases. Furthermore, a number of other affections are treated of in the book, which are in no sense "surgical."

Though the writer may have consulted his own convenience rather than the public demand with regard to the materials which compose his book, there can be no question of his entire competence to present the various subjects chosen in a manner that is far removed from mediocrity, and which should secure for his work a place in every practitioner's library. The style of the book is throughout, forcible, concise and magisterial. While abundant evidence is evinced of full acquaintance with and appreciation of the work and writings of others, there is everywhere manifested an independent tone bred of settled convictions, that is often convincing but does not fear opposition. Few innovations are presented. Indeed it might fairly be expected of a writer speaking with the authority of the author of this book, that something in the nature of reforms would be suggested. In the matter of classification and nomenclature, the writer attempts little that is original. It is, perhaps, too much to hope that such terms as "folliculitis," "cowperitis," "chancroid" will be changed immediately. Nevertheless they are bad and should be superseded.

While inflammation of the urethra is treated of in a thorough and sufficiently exhaustive manner, exception must be taken to the method of classification. The naming of the three divisions made, as "urethritis," "bastard gonorrhœa," and "gonorrhœa," is little less than an abuse of nomenclature. Urethritis is simply inflammation of the urethra—nothing more or less. But the writer restricts the term to that form of inflammation which is not virulent and from which the gonococcus is presumably absent. What the *raison d'être* of the division "bastard gonorrhœa" may be it is difficult to see. The only difference between it and what is termed "urethritis" appears to be that the former is dependent upon a previously "damaged urethra." "Gonorrhœa" (a word it would be desirable in a scientific treatise to discard except as a synonym) is used for that form which is regarded as the effect of a specific micro-organism. The writer's position with regard to the gonococcus of Neisser would seem to be somewhat infirm. While firmly convinced that it is the necessary cause of "gonorrhœa," he admits that it may be present without manifesting any virulence or contagiousness, and also that clinically "gonorrhœa" may be indistinguishable from "urethritis." In fact it would seem as though the relations of the gonococcus to gonorrhœa was hardly better established than that of the bacillus of Lustgarten to syphilis, and that as the syphilis bacillus is to the smegma bacillus, so is the gonococcus to the urethro-coccus.

With regard to the use of balsamics in gonorrhœa, the advice is somewhat at variance with what is commonly given. Most authorities regard them as useless or harmful in very severe cases during the early stage of the disease, and recommend that their use be deferred till the stage of decline has begun, which is indicated by the admixture of a considerable portion of mucus in the urethral discharge. Keyes advises them in small doses, at an early period to moderate the ardor urinæ, and diminish the discharge. For this purpose he maintains that the oil of sandal-wood and copaiba are more efficacious than the cubeb preparations, which is contrary to the opinion of Milton and others. It is a little surprising that a remedy of such evan-

escent effect as cocaine is commended as an injection during the acute stage for ardor and chordee.

One of the more interesting parts of the work, is that which treats of urethral stricture and spasm. Though well known as an opponent of the views of Otis in this connection, the author's opposition is expressed in a moderate and conservative manner, and with considerable reasonableness. The writer deprecates divulsion for the anterior urethra, but in accounting for the therapeutic effect of gradual dilatation in this region when he attributes everything to stimulation of absorption, it is questionable whether he does not ignore a mechanical factor which may play a very important role. At the commencement of dilatation in strictures of very small calibre, it is almost inevitable that certain small tender bands will be broken down at once, never to return, even with the gentlest manipulation, and in strictures of considerable thickness and extent, it is more than probable that however gradual the dilatation, a part of the effect is attributable to the sundering or separation of contracting fibres little by little, and is in fact therefore divulsion effected very gradually.

In the management of prostatic hypertrophy with obstructive, enlargement of the third lobe or urethro-vesical fold where surgical interference is necessary, the external is preferred to the internal operations. Neither Harrison's "punch" nor the instruments for crushing or ablating of Mercier are approved.

Diseases of the testicle receive a due proportion of consideration and the points of differential diagnosis are set forth with especial care. In the treatment of the acute stage of epididymitis the writer knows of no better remedy than the tobacco poultice. Less value is attached to strong nitrate of silver applications, and no mention is made of the use of the Paquelin cautery that has been recently employed at Charity with no little success.

The unpleasant topics relating to sexual diseases such as "impotence," "self abuse," "pollution," "sexual perversion," etc., are treated with much good sense and in altogether wholesome fashion.

Probably the most valuable portion of Dr. Keyes's book is that relating to bladder diseases, and more particularly that on the management of stone in the bladder. The author's radical partisanship for Biglow's method and his wide experience in litholapaxy render his views and utterances on this subject especially interesting. The description of the operation and its indications are given with clearness and much minuteness of detail.

About one third of the book is devoted to "chancroid" and syphilis. The word "chancroid" has become so firmly established in this country it is perhaps useless to inveigh against it. Nevertheless the name is absurd. "Chancre" is properly (originally and etymologically) speaking a corroding ulcer, usually of venereal origin. Doubtless the sores to which the name was originally given were rarely syphilitic, or at least were not usually so. The initial lesion of syphilis is not essentially an ulcer. The typical initial lesion is probably never so. Ulceration when it occurs is an accident. To call the common ulcerating venereal sore that does not infect, "chancroid,"—that is like a disease whose essential characteristic is ulceration—after a lesion which is not essentially an ulcer, is naming the greater after the less. When Clerc first coined the word he had a logical reason for it, but since then the premises on which his reasoning was founded have been shown to be false.

Keyes is a firm believer in the independent nature of the simple chancre

as opposed to the view that it is a simple inflammatory lesion and his arguments are cogent and reasonable.

Syphilis is a very difficult disease to adequately define except in very general terms. The true secret of the process is unrevealed and cannot be expressed but vaguely. To call it a "dyscrasial blood-disease" seems only an indifferent approximation to the truth. Undoubtedly in constitutional syphilis there is an altered composition of the blood and it is doubtless through the circulation that the symptoms are generalized. In what degree, though, the circulation shares this function with the nervous system is unknown. But the blood infection can scarcely be said in any immediate manner to be the cause of isolated gummatous products of syphilis, nor has it yet been shown to be the source of the primary lesion. But the writer apparently assumes the general disease to be the cause of the manifestations in the primary stage not as a hypothesis but as an established fact. No argument apparently is deemed necessary. No attempt is made to account for the two separate incubations for the initial lesion and for the general manifestations, nor is it explained why it sometimes happens that when more than one inoculation is effected, successive chancres appear with distinct periods of incubation. These facts are not easily explained on the assumption that the chancre is a constitutional symptom and the subject would seem worthy of some discussion.

In the treatment of chancre, Keyes is strongly opposed to beginning internal treatment till the disease is known to be syphilis beyond a peradventure. "Where there is the least shadow of doubt," he says, "no mercury should on any account be administered, until an eruption has cleared up the diagnosis," and in another place we are told that "diagnosis sufficiently accurate to commence treatment upon, can only be made by confrontation—establishing the syphilitic disease in the person from whom the chancre was derived, or by waiting until some positive corroborative signs of secondary syphilis appear." If with the appearance of the chancre constitutional disease is already present, there must be an advantage in beginning general treatment as early as possible. There are many cases in which the induration and adenopathies are sufficiently characteristic to justify the strongest presumption at least of syphilis. By the delay of a few weeks at this important period, is it not possible that valuable time may be lost? But we must wait for constitutional symptoms it is said. The diagnosis is all important. Once a celebrated goose was sacrificed and a golden opportunity lost through too great eagerness to make a diagnosis. We must wait lest "the surgeon, perhaps, throws doubt and discontent, sometimes even torture into the whole subsequent life of the patient, who is constantly alarmed by every pimple, every ache, every unusual feeling he may have through life, fearing it may be the beginning of the long-delayed onslaught of his imaginary foe." Syphilophobia is indeed a deplorable malady, but what reason is there to suppose that it would be more apt to be fostered by a consciousness that rational treatment had been employed in the beginning, than by a feeling that some possible measure of prevention had been neglected.

But an added reason is assigned why constitutional treatment should not be commenced during the primary period. We are told that "a few days of mercurial treatment in some cases will disturb the regular development of symptoms, perhaps prevent their appearance altogether in a form which would be readily recognized, and in face of such a case if the diagnosis of

the nature of the chancre had been doubtful, how much more so would be that of the subsequent syphilis?" An excellent argument we should say for early treatment. If we can by the administration of mercury during the primary stage produce such decided effects upon the course of the disease, have we not the best incentive to administer it? If we wish to cure malarial disease we first seek to break up its orderly course the regular development of its symptoms, and when we succeed in doing that we think we have made good progress toward controlling the disease. Diday and others maintain that prolonged periods of incubation in syphilis portend a comparatively mild course of the disease and Keyes also admits there is in this "a measure of truth." It would seem then as though, all things considered, there was sufficient reason for early anti-syphilitic treatment where the lesions bear the marks of specific infection even before the diagnosis has been positively established by the occurrence of general manifestations.

The subjects bearing upon the various modes by which syphilis may be transmitted are extremely interesting, and while the writer considers them at some length it cannot be said that he has done much to enlighten any of their more intricate features. That form of transmission implied by the French term *choc-en-retour*, is characterized as a "misty condition," but it can scarcely be said that its mistiness is dispelled by the following deliverance: "The semen being harmless by inoculation, if it finally becomes proved (as it well may be) that the mother remaining healthy the child is healthy whether the father is syphilitic or not, in such case the scientific explanation of *choc-en-retour* falls to the ground of necessity." The scientific explanation of *choc-en-retour* is founded on two presumed facts—viz.—(1.) That the semen of a syphilitic father is capable of infecting the ovum at conception whether such semen has thus far been found "harmless by inoculation" or not, and (2.) That a fœtus or ovum so infected by the father always infects the mother (unless she has been previously diseased) as inferred from "Colles's law." Hence when the mother remains healthy it is simply evidence that the ovum was not infected and the assertion that thereby the scientific explanation of *choc-en-retour* is disproved clearly involves a *petitio principii*.

Under the subject of syphilis, as throughout the book, matters relating to treatment receive the most particular attention. Here as elsewhere the methods advised whether old or original are presented in a masterful manner that bears the impress of independent judgment and experience. The author's comments on certain alleged specifics, more especially the much vaunted *succus alterans* are excellent as is his estimate of the uses of the Hot Springs of Arkansas, and for many practitioners, would be very profitable reading.

In his method of using mercury the writer has endeavored to introduce something like scientific precision. Laudable as this aim is, so long as our knowledge of the disease remains as inexact as it is so long must treatment be more or less empirical. The adjustment of the dose according to the author's plan may answer well as a general scheme, but each case has an individuality that demands more or less peculiar management. The writer has a predilection for the protiodide administered by the stomach. Though indications for fumigation, hypodermic injection or inunction are given, these methods are evidently regarded as of comparatively little importance. In connection with the inunction plan but two methods are mentioned, that of Teales, which consists in the prolonged application to the body of a mercur-

rial ointment, and is said to be especially suitable for young children, and the method described as in vogue at the Hot Springs, consisting of frictions of mercurial ointment to the back, requiring of course the assistance of an attendant. It is singular that the Vienna method should be wholly ignored. The advantages of this plan, which consists in inunctions to four or five different regions of the body on different days, are that there is less liability to irritation of the skin than when the ointment is constantly applied to one region, and furthermore, that by operating gradually over a large extent of the body the facilities of absorption are increased. No mention is made of the mercurial soaps in this connection.

Keyes's system of administering mercury by the stomach consists in ascertaining first what is the "full dose," as he terms it, which is done by gradually increasing the amount up to the highest point of toleration, as evinced by slight manifestations of irritation at some of the emunctories. This maximum dose is reserved for exacerbations of the disease requiring especially active treatment, while meantime the mercurial is given continuously in what is termed the "tonic" dose, which is one-half or one-third of the "full" dose. The tonic dose is continued uninterruptedly, unless circumstances occasionally require the maximum dose for a while, for a period of about two and a half years. If one is convinced that every case of syphilis demands continuous routine treatment for so prolonged a period, Dr. Keyes's plan is perhaps as good as any other, but it is evident that it embraces various sources of inaccuracy. First, in taking irritation of the emunctories as the criterion of "saturation" with the drug there is a great possibility of error. Gingivitis, ptyalism or irritation of the bowels or the skin may depend upon a number of accidental circumstances that bear very little relation to the amount of mercury taken up. The form of mercurial has much to do with it. This particular source of error is largely avoided by the use of a uniform preparation of the protiodide. But there is a mass of circumstances depending on the individual that may cause toxic manifestations to occur, and not uniformly in the same individual at all times, and there is little reason to suppose that these toxic symptoms bear any necessary relation to the degree of saturation of the economy with the drug. In estimating the "tonic dose" from the full dose there must therefore be a wide margin of uncertainty. A tonic dose at one time may be toxic at another. Some subjects tolerate mercury in large doses without sign of disturbance. In such would the estimated "tonic" dose when continued for two years be regarded as equally harmless with the very much smaller dose in another patient?

With regard to the propriety of the term "tonic" in connection with mercury, it is not necessary to enter upon any discussion here. Whether in small doses, tonic or not, it has been pretty plainly shown by Liégeois and Keyes that such doses, if injurious at all, are ordinarily imperceptibly so; but how much of the cure of syphilis is to be attributed to these small doses is uncertain. Certain it is that dependence on them ceases so soon as an important emergency arises or any exacerbation occurs. Perhaps were the dose always confined to the "tonic" measure no harm would result. Dr. Keyes has done much to rob the drug of imaginary terrors, but we are scarcely ready to trust its garb of a tonic. Mercury we know too well as the enemy of life, and suffer its company only as it is a greater enemy to syphilis.

E. B. B.



JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

AUGUST, 1888.

No. 8

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**Original Communications.**

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REPORT OF A CASE OF THE MYCOSIS FONGOÏDE OF ALIBERT.

BY

HENRY WM. BLANC, M.D.

Dermatologist to the Charity Hospital, New Orleans.

*(Concluded from page 265.)*

**F**RESHLY-DRAWN blood has been recently examined in the ward by my friend, Dr. A. McShane, who used the hæmacytometer of Gowers. The doctor found in a cubic millimeter of blood 4,680,000 red corpuscles and 36,000 white corpuscles, and remarks: "The ratio of white corpuscles to the red is thus—1 to 130, which ratio is much greater than that observable in health." Now when we consider that the usual proportion is 1 white to 350—500 red, we see that there are at least three times as many leucocytes in the blood as there should be in health. There seems to be no very marked diminution of red cells.

EXAMINATION OF TISSUES.

For microscopical study tumors were removed from the patient at three different times, and sent to the pathological department of the hospital. The first specimen, already referred to, was stained for leprosy bacilli, and none found after the examination of many sections. A second, the size of a cherry, was removed November 22d, and a third about six weeks later. The last specimen was the smallest focus of disease that could

be found, and was the size of a small pea, having healthy tissue attached, and included the whole thickness of the skin.

These were all sent fresh to Dr. H. D. Schmidt, the distinguished pathologist of Charity Hospital, New Orleans, who has studied them carefully, and, after much labor, has submitted to me the following report with drawings from his own skillful and accurate pen :

"The tumor first sent to me for examination had been taken from the side of the patient just over the liver, and from my microscopical examination of thin stained sections of it, I was rather inclined to regard it sarcomatous in its nature. Being unable to discover in the sections any trace of a reticulated adenoid tissue, mentioned by some authors, and to which you particularly directed my attention, I suggested to you to remove from the body of the patient one of the smaller tumors of recent growth on which we might possibly observe the histological development of the neoplasm. What I had suspected proved true, for the sections made of this second and smaller tumor which you removed from the arm of the patient, though not showing the very first stage of the disease, exhibited, nevertheless, the true structure and development of the growth to full satisfaction. As will be seen directly, there was some difference observed in the structure of the two tumors, though they were derived from the same patient, a phenomenon, which, however, admits of a satisfactory explanation. Although the larger tumor, taken from the side of the patient, was the first examined and studied, I shall commence my description of the nature and development of this neoplastic growth with the smaller and last specimen taken from the arm of the patient.

To illustrate the subject, and to render its description more perspicuous to the reader, I have carefully made from the microscope a number of drawings representing the different phases of development of the tumors of mycosis fungoides; they will accompany this report.

In turning now our attention to Fig. 1, which represents a section of the smaller and younger growth, magnified about 40 diameters, we notice at *a* the so called horny layer (stratum corneum), at *b* the layer of the prickle-cells, or mucous layer (rete or stratum mucosum) of the epidermis, and at *c* the papillary layer (pars papillaris) of the corium. In the latter we notice a number of well-defined round spaces, or areolæ, *d*. These spaces are also met with in the pars reticularis of the corium, where they represent the areolæ, or lymph-spaces, situated between the bundles of connective tissue of this part of the skin from which the radicles of the lymphatic vessels take their origin. These spaces, which differ considerably in diameter, increase in size during the development of the tumor.

c  
e  
e

FIG. 1. SECTION OF THE ENTIRE TUBERCLE, TAKEN FROM THE ARM OF THE PATIENT,  
MAGNIFIED ABOUT FORTY DIAMETERS.

a—Stratum corneum. b—Stratum mucosum. c—Pars papillaris. d—Lymph-spaces of the corium, filled with stellated cells and their reticulum. e—Lymphoid network, consisting of coarse fibrous bundles. f—Hyperplastic connective-tissue bundles of the corium, forming a sort of a capsule around a part of the tumor, consisting of a number of the coarse reticula, and giving rise to numerous septa passing between the latter. g—Transversely and obliquely cut bundles of connective tissue of the corium. h—Subcutaneous connective tissue.

In some instances, even, a number of the lymph-spaces fuse with, or coalesce into one another (Fig. 1, *e*), forming, surrounded by a sort of a capsule of hyperplastic connective-tissue bundles (*f*), a compact mass, which, as may be observed in this figure, constitutes the greater part of the whole tumor.

Let us now trace the mode of development of this neoplasm by referring to Fig. 2, which represents a small portion of the tumor seen in Fig. 1, including the epidermis and a small part of the corium, magnified about 250 diameters. Leaving the strata of the epidermis to a later consideration, we shall first direct our attention to a number of small round cells (so-called leucocytes or lymph-cells) observed between the bundles of connective tissue of the papillary and the adjacent reticular layers of the corium. In the drawing (Fig. 2) before us, these cells do not appear very numerous, for the reason that this specimen of the neoplasm did not represent its very first stage of development. But judging from my own observation, and from the statements of other pathologists, I may safely presume that these small cells are the first pathological elements appearing in the history of the neoplasm under consideration, giving rise to the subsequent pathological changes in the corium of the invaded part of the skin. Though not represented in my drawing (Fig. 2), I have observed two nuclei in a number of these cells, and also, in many instances, two of the cells lying very close to one another, thus showing that their multiplication takes place by the mode of division. As regards their origin, it will, of course, be difficult to determine whether they are derived from the blood or lymph, or from the normal connective tissue cells.

Throughout both the papillary and reticular layers of the corium, will be observed a number of smaller or larger elliptoidal spaces closely packed with small cells (Fig. 2, *e*), which cells have become polygonal in shape by mutual pressure. These cell-nests, as they may properly be called, have very probably been formed by the multiplication of one, or even more of those individual cells met with between the connective-tissue bundles. In the loose tissue of the pars reticularis (Fig. 1, *f* and Fig. 2, *h*), these cells, when increasing in number, simply fill up some of the small oblong interspaces of the loosely arranged connective-tissue bundles, whilst in the denser tissue of the pars papillaris (Fig. 1, *c* and Fig. 2, *d*), the small elliptoidal spaces are formed by the cells, which, during their increase in number, press asunder the parallel and closely arranged connective-tissue bundles. At any rate, in both instances, the cells gradually assume a more multipolar form, from which filiform processes are growing out, which, by growing toward, and fusing with those of neighboring cells, eventually form a sort of reticulated so-called adenoid tissue (Fig. 2, *f*) mentioned by some of the

authors in their description of the pathological anatomy of these tumors. The final conversion of the small round lymph-cells into adenoid tissue, however, does not only take place in the cell-nests, but also in those single individual cells distributed throughout the connective tissue of the papillary and reticular layers of the corium (Fig. 2, *d* and *h*), where they may be observed to assume also, as in the case of the cell-nests, a multipolar form; while the filiform processes, proceeding from neighboring cells, likewise unite to form an imperfect reticulum throughout the connective tissue.

FIG. 2. SMALL PORTION OF THE EPIDERMIS AND UPPER PART OF THE CORIUM OF THE GROWTH OF SMALL TUMOR, REPRESENTED IN FIG. 1. MAGNIFIED ABOUT 250 DIAMETERS.

*a*—Stratum corneum. *b*—Stratum mucosum. *c*—Stratum granulosum. *d*—Pars papillaris of the corium, containing small round and multipolar lymph-cells. *e*—Nests formed by these cells. *f*—Nests of which the cells have become multipolar, their processes uniting with one another to form the adenoid network of fine fibrillæ. *g*—Areolæ, or lymph-spaces, of the connective tissue of the corium, filled with stellated cells and their reticulum. *h*—Connective tissue of the pars reticularis, containing stellated cells with their network. *i*—Bundles of hyperplastic connective tissue fibres of the pseudo-capsule, Fig. 1.

The adenoid networks above described, formed both from the cell-nests and from those single cells distributed throughout the connective tissue, consist of fine fibrillæ connecting the individual multipolar, or stellated cells with one another. There are, however, other so-called lymphoid networks observed in this tumor which consist of more or less *coarse* connective tis-

sue fibres, and contain, besides a very small number of multipolar cells, also a number of single nuclei. These networks, (Fig. 1, *e*) appear to be derived from the endothelial cells lining the round and larger lymph-spaces of the connective tissue of the pars reticularis. From the protoplasm of these cells also, as in the case of the cell-nests above described, processes grow out, which, by meeting and uniting with the processes of neighboring cells form the reticulum, which here, however, consists of more or less thick and heavy bundles of connective tissue fibres and comparatively small meshes (Fig. 3, *a*). In the coarse bundles of this reticulum a number of small single nuclei are observed, which represent the remains of the nuclei of the original multipolar cells; the whole protoplasm of the latter having been used up in the formation of the fibres of the reticulum. Only here and there some of the original multipolar cells are still observed in the meshes of the reticulum, as seen magnified about 250 diameters, in Fig. 3, *c*.

In referring again to Fig. 1, which represents a section of the whole small and more recent tumor, there will be observed a considerable number of these coarse reticula (*e*), just described. They are enclosed in a sort of a capsule, formed by coarse bundles of hyperplastic connective tissue of the pars reticularis (*f*), from which processes are seen to arise and proceed into the interior of the whole mass, forming septa (Fig. 3, *b*) between the original reticula. The latter, circumscribed by the capsule, form almost the greater part of the whole tumor.

Some of the spaces, filled with multipolar cells united by the fibrillæ of their processes, are also observed at the borders of the papillary layer, as represented in Fig. 2, *g*, and Fig. 1, *d*. These spaces are likewise, as it appears, original lymph-spaces, and the cells which they contain may possibly be derived from the endothelial cells lining these spaces; though, on the whole it may be said that it is very difficult to determine the true origin of these cells.

In reviewing the process of the formation of the adenoid network from the cell-nests, such as I have described it above, a certain obscure point relating to this process will be noticed to still remain unexplained; this point involves the question: In what manner can the interspaces or meshes observed between the fine fibrillæ processes of the multipolar cells, and forming the adenoid network (Fig. 2, *f*, and *g*), be formed from a *closely packed* mass of cells, as seen at *e*? The only plausible explanation which I find to meet this question is: That the multipolar cells, while they give rise to their filiform processes, secrete a fluid, which, by gradually distending the space or wall of the cell-nest, makes room for the growing processes and their filaments, which room or space becomes eventually identical with the meshes of the network.

As regards the connective tissue of the corium, it is found to be in a hyperplastic condition, indicated particularly by the coarse bundles of connective tissue fibres of the pars reticularis (Fig. 1, *f*, and Fig. 3, *b*), as well as by the deformity, or even complete disappearance of the papillæ by the hyperplasia of the connective tissue of the pars papillaris (Fig. 1, *c*, and Fig. 2, *d*).

In passing now from the consideration of the corium to that of the epidermis of the tumor in question (Fig. 2, *a*, *b* and *c*), it may be stated that, here, the mucous and granular layers, as well as the septum lucidum showed no abnormal changes, whilst the horny layer, besides having diminished in thickness, pre-

### Fig. 3

FIG. 3. SMALL PORTION OF THE COARSE ADENOID RETICULA REPRESENTED IN FIG. 1. MAGNIFIED ABOUT 250 DIAMETERS.

*a*—Coarse bundles of connective-tissue fibres of the reticulum. *b*—Bundles of hyperplastic connective tissue, derived from the pseudo-capsule and forming septa between the adenoid reticula. *c*—Original multipolar cells that have not taken part in the formation of the reticulum, seen in the meshes of the latter. *d*—Small nuclei, representing the remains of the nuclei of the original multipolar cells from which the reticulum was formed.

sented a peculiar appearance, namely: the walls of its component cells, instead of being marked by a fine double contour, appeared, in this case, to be composed of several superposed layers, indicated by several lines, as may be observed in Fig. 2, *a*. In examining the drawing more closely, however, it will be observed that these lines do not correspond to the outlines of the individual cells, as they should in representing the outlines of individual layers, or deposits, upon the interior of the cell-walls; but that, on the contrary, the greater number of these

lines pass from one cell to a neighboring one, either in a parallel or oblique direction. For the latter reason it appears to me more probable that the super-numerous lines of these cell-walls indicate the walls of *collapsed* cells, a phenomenon which, at the same time, would satisfactorily account for the decrease in thickness of the horny layer.

Having thus far treated of the structure and development of the smaller and more recent tumor, which you took from the arm of your case of mycosis fungoides, let us pass to the consideration of the structure of the tumor which I first examined, and which you took from the side of the patient just over the region of the liver. In doing so we shall refer to Fig. 4, which represents a small portion of the irregular surface of this tumor, magnified about forty diameters.

At the first glance upon this drawing we must notice the considerable deformity of the layers of the epidermis, caused by the abnormal growth of the corium. As in the younger tumor above described, we likewise find here the horny layer (*a*) of the epidermis reduced in thickness. The mucous layer (stratum mucosum *b* and *c*), also, is found deformed by the abnormal growth of the papillæ (*c*), as well as by the rest of the corium (*d*). Although this tumor was larger, and represented an older growth than the one described above, its microscopical examination and study showed the absence of any formation of lymphoid so called adenoid tissue, the principal pathological changes simply consisting in the production of very numerous cells, and, besides some spindle-celled sarcomatous stroma a hyperplasia of the connective tissue of the corium, indicating a lower grade of organization than met with in the smaller tumor above described.

In referring again to Fig. 4, *d*, which represents the corium of the tumor, the cells will be observed arranged in larger or smaller groups, which, on their part, are arranged in rows; they are imbedded in the hyperplastic connective tissue. Most of the empty spaces, observed in this part of the tumor, represent the sections of blood-vessels, while others may represent sections of lymph-spaces.

If we now examine Fig. 5, representing a small portion of corium, as exhibited in Fig. 4, magnified about 250 diameters, one part of these cells will be found lining sections of lymph-spaces (*a*), while the other part is imbedded in the hyperplastic connective tissue (*d*). At the same time, a slight difference may be observed in the comparative shape and size of these cells, for whilst those in the lymph-spaces exhibit a somewhat irregular form, resembling the endothelial cells of vessels, the other, placed between the fibrous bundles of the connective tissue, are somewhat smaller in size and more spindle-shaped. Judging from the small groups (*b*), in which the cells are placed closely



to one another, their multiplication must take place by the mode of division. In this drawing, also, a number of empty spaces (c) are met with, which, here, very probably, represent sections of lymph-spaces.

From what I have already said above, it may then be presumed that the cells met with in this tumor, are derived from

- 1 -

c

ca

FIG. 4. A SMALL PORTION OF THE IRREGULAR SURFACE OF THE LARGE TUMOR.  
MAGNIFIED ABOUT FORTY DIAMETERS.

ca—Stratum corneum. bb—Stratum mucosum. c—Deformed papillæ of the pars papillaris, containing nests of neoplastic cells, probably derived from the cells in the walls of the blood-vessels. d—Corium, containing rows of neoplastic cell nests.

the endothelial cells lining the areolæ or lymph-spaces of the connective tissue, as well as from the small cells placed between the fibrous bundles of this tissue itself. But in referring again to Fig. 4, and in carefully examining the greatly deformed remains of the papillæ, as shown in this drawing at c, a number

of rows, formed by groups of cells, will also be observed in this part of the tumor. And, it will furthermore be noted, that these rows correspond in their arrangement to that of the blood-vessels of the normal papillæ of the corium, for which reason I am much inclined to regard these latter cells as having been derived from the cells contained in the walls of the blood-vessels. A part of the cells met with in the *pars reticularis* may have originated in the same manner; this postulate appears to me justified, as I have failed to discover any minute blood-vessels in the sections of this tumor.

Although throughout the greater part of this tumor the groups, or nests of cells, appeared to be imbedded in a hyperplastic connective tissue, as represented in Fig. 5, there were, nevertheless, a number of places met with, particularly in the deformed papillæ, in which a stroma, consisting of minute spindle-shaped cells, could be distinguished, and in which, besides, the whole mutual arrangement and character of all the histological elements of the growth pointed to the character of sarcoma, which observation, during my first examination of this tumor, had inclined me to regard the whole growth as sarcomatous in its nature.

As regards the epidermis of this tumor, it may be stated, that whilst its horny layer was greatly reduced in thickness, and exhibited the same changes in the walls of its cells, already described in connection with the smaller and younger tumor, the stratum mucosum appeared, though deformed in its general shape, to have undergone but very slight changes in its histological character.

In reviewing the descriptions of the structure and development of the two tumors taken from one and the same patient, though from different parts of his body, a difference in the character and arrangement of the histological elements of the tumors, as well as in the general construction of the latter, will be found to exist. At first sight this difference appears so striking that, without the knowledge of both tumors having been developed upon the same patient, the pathologist, in studying the character of these tumors, might very easily be led astray, and regard them as distinctly different in their structure, and as being derived from two different patients. In knowing, however, that these tumors have in reality been developed upon the same patient, and in studying and comparing their structures with one another a little more closely, it will be found that the two growths simply represent different stages of development. For, whilst in the one the pathological process advances only to the formation of a great number of cells appearing mostly in the form of groups or nests of cells—as well as, though only in some parts of the tumor, to the production of a number of small spindle-shaped cells, representing, as already

mentioned above, a sarcomatous stroma—we find in the other tumor the same production of cells, probably of the same origin, but endowed with a superior force of organization, and in consequence developing into a higher kind of tissue, resembling in structure that met with in the lymphatic glands known as adenoid tissue. And it is this difference in the degree of development observed, as in the case under consideration, to exist in the tumors derived from different patients suffering from the same disease, and causing a different appearance of the structure of these growths, that has given rise to the discrepancy of

Fig-5

a

FIG. 5. SMALL PORTION OF THE CORIUM OF THE LARGER TUMOR, REPRESENTED IN FIG. 4. MAGNIFIED ABOUT 250 DIAMETERS.

a—Sections of lymph-spaces, containing endothelial cells. b—Cell nests, the cells of which have arisen from one cell, showing the multiplication of these cells taking place by the mode of division. c—Probable section of lymph-spaces. d—Hyperplastic connective tissue, containing smaller neoplastic cells, many of which are spindle-shaped.

opinion as regards the exact nature of the tumors and the disease in question, which has existed, and to a certain extent perhaps still exists among some pathologists.

Abstaining from making any special remarks as to the etiology of this peculiar affection, I will simply repeat that the first pathological changes observed in the skin consists very probably without regard as to their origin, in the appearance of very great numbers of small round cells. In the small tumor, examined

and studied by myself, this very first stage of the development of the neoplasm had, as I have already mentioned before, almost passed, though many of these small cells were still observed throughout the papillary layer of the corium, as seen in Fig. 2, *d*. But in examining Fig. 1 of the illustrations accompanying the statements of Dr. Longstreet, concerning his examinations of the tumors of Dr. Duhring's case of this disease (*Archives of Dermatology*, January, 1879), this stage, characterized by the appearance of great numbers of small lymph-cells in the corium will be found represented.

As regards the adenoid net-works which I have described above, I may state that it is only the one consisting of fine fibrillæ, which I have thus far seen described and represented by a few authors in their writings on the subject, whilst the reticulum, consisting of those coarse bundles of fibres, as represented in Fig. 3, I have as yet never seen mentioned or represented by drawing.

As to the etiology and exact nature of mycosis fungoides, I shall for the present likewise forbear from expressing any positive opinion, and, in consequence, classification of this neoplastic growth, though I may simply say that thus far, I am rather inclined to regard it as being in some way or other related to the lymphatic system. The designation 'mycosis fungoides,' at any rate appears to me wrong. Ranvier's 'Lymphadémé cutanée,' though it may not be perfectly correct, nevertheless appears to express somewhat closer the true nature of the neoplasm than the above original designation."

In reviewing the history of this remarkable case, we find that without apparent cause, the disease began as an eruption similar to, if not identical with eczema, accompanied by an intense pruritus which has continued to this day (May 12, 1888).

The tumors, which later on formed a conspicuous feature of the disease, did not appear until after the frost-bite in January, 1887, or three and a half years after the beginning of cutaneous inflammation. The tumors have spared no portion of the body except the face and scalp, and occur on the thinnest as well as the thickest surfaces. Though tender to the touch they are not painful, and though congested, they have never bled from ulceration.

Their occurrence on the hard palate, the external auditory meatus, the glans penis, and occasional tenderness within the rectum during defecation, with bleeding therefrom, go to show that the mucous membranes are by no means exempt from the disease. How far the mesenteric glands and internal organs are affected, it is at present impossible to say.

The spontaneous appearance and disappearance of the tumors is an interesting and curious feature of the disease, for several that grew to the size of a pecan-nut were observed to pass through their stage of growth and resolution within six weeks, while certain others, half the size, would remain three times as long. In a general way it may be stated that the soft, discharging tumors grew largest and disappeared soonest.

Thus far the disease seems to be dermal rather than hypodermal, beginning in the skin and remaining there. It were hard to say how true this statement may be with reference to the toes; but as the inflammation has not yet destroyed the deeper structure after months of disease, it can be understood how superficial the morbid process must be. The only subcutaneous inflammation noted has been that of the numerous enlarged lymphatics; and it is possible that the swelling mentioned as having occurred in the region of the saphenous vein in the thighs, was also due to inflammation of the lymphatic glands distributed along the course of that vessel.

#### CONCLUSION.

We see, then, in this disease an unusual involvement of the lymphatic glands, many of which, so small and insignificant in the normal state as not to be noticed in the majority of dissections, become irritated and swell to the size of a butter-bean; in one case attaining the size of a pigeon's egg. In addition to the clinical fact of slight but constant oedema of the extremities, the microscope discloses marked changes in the blood and tissues.

In the former we find a decided increase of white corpuscles; and in the latter an adenoid growth, accompanied by dilation of the lymph-spaces of the skin, with a decided hyperplasia of their endothelial cells occurring early in the disease.

Now, admitting the possibility of earlier changes than those which took place in the lymph-spaces, such as a round-cell deposit in the connective tissue of the corium, and hyperplasia of the cells of the blood-vessel walls (which latter was observed, however, only in the older tumors), I am inclined to look upon this affection as a disease *sui generis*, which, in the light of the foregoing clinical and pathological observations, is to be considered as "in some way or other related to the lymphatic system."

NEW ORLEANS, LA.

THE LIMITATIONS OF ELECTROLYSIS AS A THERAPEUTIC  
AGENT IN ORGANIC AND SPASMODIC STRICTURE  
OF THE URETHRA, WITH CASES.<sup>1</sup>

BY

F. TILDEN BROWN, A.M., M.D.

(Concluded from page 256.)

**T**HUS far the tone of this paper may suggest that I have experimented with electricity for the express purpose of finding it a failure in stricture cases. Any such intention I wish to disprove. Realizing the truth of the late Dr. Bumstead's remark that, "probably no class of affections has more thoroughly taxed the ingenuity of surgeons to discover some steady and effective method of cure, than have strictures," I took up this *new* method without bias, other than any I had imbibed from the teachings of its leading medium whose rules I had prepared myself to follow closely.

The following six cases were treated at my office. Careful records of treatment and its result were noted at each visit. All care was taken to observe every successful point ascribable to the treatment. The monotony of details will be made as short as possible. And four of the cases will be alluded to only in the appended table, which, it will please you to know, is not to be read this evening.

*Case 1st.*—H. D., æt. 25. Gonorrhœa eight years ago, symptoms of stricture four years later; two and a half years ago had retention, of which he was relieved at a dispensary by passage of a very fine catheter; immediately after, three of the smallest steal sounds were passed. Patient believing the relief was permanent failed to return as advised. Has had no treatment since and when I first saw him, February 11th, he had noticed for several months a gradual decrease in size of stream, which was voided with increasing muscular effort. During day micturition once an hour, not obliged to get up at night. Urine passed before me issues in a very fine and erratic stream.

*Examination of Urethra.*—Meatus admits 24 Fr. All instruments are refused at four inches until after a half hour's work with two whalebone guides one is passed to the bladder, on this Gouley's grooved sounds up to 8 Fr. then solid sounds to 14 Fr. No pain. No blood.

Next day patient reports intervals of micturition increased to three hours. After a preliminary introduction of the same fine

<sup>1</sup> Read before the Surgical Section of the New York Academy of Medicine.

instruments and small sounds. A 15 Fr. bougie-a-boule, shows strictures at four, four and a quarter, four and a half and five inches.

It is fair to infer that the strictures at four, and four and a quarter rest on one base of stricture tissue, but as later investigation reveals, the others are each at times more or less influenced by underlying muscular spasm, if they are not purely spasmodic. I now begin the treatment of these strictures with electrolysis.

Eighteen Fr. bulb negative electrode on straight staff is passed to face of four inch stricture but refused after moderate pressure for ten minutes with five milliamperes, bulb withdrawn, its shoulder covered with white foamy mucus, strongly alkaline in reaction. Now a 16 Fr. bulb is held for eight minutes with five milliamperes, when it passes all but five inch stricture. After passing electrode to and fro over this region a velvety smoothness of the strictures has supplanted the snappy hardness felt before. Without electricity, a 17 and an 18-bulb pass all except at five inches. A No. 15-bulb without electricity now passes five inches.

Patient has felt only a moderate warmth during this treatment. On getting up he voids nine ounces of urine in a stream of such size and force as to suggest an urethra of good calibre, and strongly strengthen the belief in the spasmodic nature of the two deeper strictures.

*February 14th.*—Three days after operation patient has had no urethral discharge. No pain other than a kind of empty weakness in the bladder after micturition, probably due to rapid and forcible contraction of vesical muscles, now that long existing obstruction is partly removed or allayed.

*Examination.*—Seventeen-bulb refused at four and a half. No. 15 the same. A 17 Fr. sound is passed after awaiting relaxation. Now 17-bulb, passes all strictures, detecting distinctly one moment and not the next the strictures at four and a half and five inches

*February 19th.*—One week since first and only treatment with electricity. Patient still notices marked improvement in all his symptoms.

*Examination:* 18-bulb passes all strictures, tightest at four and a half. Now a 21-bulb after five minutes with five m. amp. moderate pressure passes all strictures; frothy blood on shoulder of bulb.

*February 26th.*—Excellent condition of urinary organs; micturition only four times a day. Has had daily a moderate chill. Probably urethral treatment has determined an expression of a condition. Patient had malarial chills two years ago.

*Examination:* 21-bulb refused at four inches.

Now a 22-bulb with four m. amp. held for four minutes goes

through with a jump; find no trace of usual four and a half inch stricture.

*March 4th.*—Had very slight urethral irritation for a day or two after last treatment. Examination: 21-bulb passes all strictures; twenty-two the same.

Now a 24-bulb with two and a half milliamperes passes all strictures in half a minute.

*March 11th.*—No irritation after last treatment. Examination: 24-bulb refused at four inches; twenty-two the same. Twenty-one passes; then twenty-two and twenty-four after a minute's pressure.

Galvanic current is now attached to the 24-bulb, and usual treatment with three milliamperes.

*March 18th.*—Excellent condition. Examination: 24-bulb refused at four and one-half inches. Now three milliamperes of current is turned on. After twenty seconds a sharp spasmodic movement is felt, when the bulb at once jumps through the stricture. Five minutes' treatment, one-half drachm of frothy blood issues with the electrode.

*March 25th.*—Urethra has been ticklish. Examination: 24-bulb refused at four inches for two and one-half minutes. Three milliamperes of current is turned on. After four minutes a strong muscular contraction throws my hand and electrode upward. As the bulb was gently replaced it passed the stricture at once. Here I must call attention to this strong spasm involving the four-inch organic stricture.

*April 1st.*—Patient in good condition. Examination: 24 bulb refused at four inches for four minutes, when it slowly passes. The deeper strictures are distinct, but much less resisting.

At this visit I test the urethra with Otis's urethrometer. From five and three-quarters to five inches—forty-five; from five to four inches—twenty-four; from four to three inches—thirty-nine; from three to two and a quarter inches—thirty-four; from two and a quarter to meatus—thirty-three; meatus itself twenty-four.

As the meatus admit only twenty-four, and the strictures will accept this without the galvanic current, the patient is dismissed with the request to report in one month for examination.

On May 6th I examined him. Twenty-four-bulb refused at four inches, eighteen passes readily, twenty-two then quite easily. It detects the four and a half inch stricture. Twenty-four will now pass. It also detects a faint stricture at three and a half, for which I cannot account, unless the contracted meatus has instituted a faint reflex spasm here.

All improvements in the urinary functions had continued despite the fact that during the past month he has been very irregular in his habits.



I feel that the result in this case was most satisfactory. It is not necessary to dwell upon it. Those acquainted with urethral disease will see that muscular spasm was the main cause of this patient's trouble. The case is an excellent example of many which are reported as wholly or almost impassable organic stricture cured by electrolysis.

*Case 2d.*—J. P., æt. 39. Gonorrhœa eight years ago ; patient has noticed more or less discharge since that time, and of late a diminished stream of urine. No irritation or undue frequency in micturition.

**Examination:** 18-bulb finds sharp strictures at one, one and one-quarter, one and three-quarters, and at two and one-eighth inches where it is refused. Pass a 17 Fr. sound to bladder. Commence electrolysis with 18-bulb, using from four to seven milliamperes ; this No. 18 after thirteen minutes passes the two and a quarter inch stricture, but finds another at two and a half which it passes in six minutes with seven milliamperes.

Treatment for four minutes over these strictures does not dispel their hard and snappy margins. Bulb on withdrawal has dense white frothy mucus. No pain on urination immediately after, in office.

*March 4th.*—Patient suffered for several nights with chordee, a thing he has never had before. Although no pain at the first micturition, he felt some scalding with succeeding acts the rest of that day. **Examination:** 17-bulb refused at two and a quarter.

Now 21-bulb with four milliamperes is refused for five minutes at two and a quarter inches, and for the same time with six milliamperes. Twenty one changed for 18-bulb, this with seven milliamperes is also refused at two and a quarter inches. Dismiss patient.

*March 11th.*—For three days after last treatment severe burning during micturition. No increased frequency.

**Examination:** unable to pass anything larger than fifteen.

Now 18-bulb with six milliamperes passes two and a quarter after eight minutes, two and a half after five minutes more. The same pressure is maintained as when examinations are made without the electricity.

*March 18th.*—For twenty-four hours after last treatment, patient suffered great pain on urinating. Moderate urethral discharge has appeared. He notices for past several days that his stream has been smaller.

**Examination:** eighteen refused at one and three-quarters, same bulb with four milliamperes is refused for four minutes ; 15-bulb substituted with three milliamperes, it passes all in one minute. Replace 18-bulb which with five milliamperes passes one and three-quarter inch stricture in six minutes, and a moment

later that at two and a quarter. To relieve painful micturition in office inject cocaine solution.

*March 25th.*—Patient again experienced chordee and burning micturition after last treatment. Patient thinks two more treatments will cure him! Examination: 15-bulb refused at one and three-quarters, fourteen after much opposition passes.

Now the 18-bulb, with four milliamperes and moderate pressure, is refused at one and three-quarters for eight minutes. Change to fifteen, which passes; use eighteen again, which after five minutes passes, causing considerable pain.

The evident tightening of the strictures in this case cause me to discontinue all treatment, and to see after one month what has been effected by vital absorption.

*April 22d.*—Examination.

One and three-quarter inch stricture refuses No. 12 after smaller ones have been passed.

Two and a quarter inch stricture refuses No. 11 after smaller ones have been passed.

The train of bad results directly attributable to the electrolysis is too manifest to require comment.

This unquestioned case of organic stricture completely refutes all statements to the effect that strictures of this nature gradually enlarge by absorption between treatments so as to later permit the introduction of same or a larger instrument.

It would be proper to review, did time permit, some of the known laws pertaining to the electrolysis of fluids and molten substances, as well the generally accepted theory, that of Grotthuss, explaining these phenomena: in order to contrast the behavior of a similar electro-motive force acting upon living tissues, such an investigation would, I think, at least, show that the action of electrolysis in the latter could not be easily reconciled to the theory of molecular separation and recombination along the whole path of the current as is believed to happen in fluids. Many, Dr. Tilley among them, object to the word electrolysis in this connection, and probably for the reason given. And Steavenson, although finding no fault with the term as applied, is nevertheless so well satisfied that this continuous molecular interchange does not occur in animal tissues, as to furnish him grounds for doubting the correctness of the Grotthuss theory regarding the electrolysis of fluids.

But this ponderous subject we will not dwell upon. Let us rather make a practical test which will convince us all of the truth concerning one point universally maintained by the advocates of electrolysis for stricture.

When we make a thick all-meat sandwich, where in place of the domestic bread and meat, we use meat and connective tissue, after the following fashion; first a slice of fresh beef muscle, then, thin connective tissue, such as Calf's aorta opened and spread flat, and lastly another thick piece of raw beef, care having been taken that the intervening connective tissue shall extend beyond the meat and prevent contact of their surfaces at any point. Now with a long punch made expressly for the purpose, a perfect cylinder of the entire thickness of the sandwich is removed.

This affords us a fair substitute for the urethral canal, having midway in its course an artificial stricture (Belfield may object that it is one of large calibre, since one punch has made the entire canal). Over the canal is set up an open rubber ring on a tripod base to support perpendicularly the straight insulated stem of the negative electrode bulb. The positive electrodes—a pair of platinum needles are thrust into the underlying meat slice. A negative bulb electrode, three sizes (French) larger than the diameter of the punch is now passed through the open ring of the tripod, and its point engaged in the punched out meatus; by its own weight it slowly settles down this meaty canal, until it reaches and rests upon the margin of the connective tissue aperture representing the stricture.

If now we turn on six milliamperes of electricity furnished by a Barrett chloride of silver battery, and maintain this uniform strength of current for one or two hours, at the end of this time we are prepared to note one very important point, namely, that the electrode bulb is just where it was when the electrolytic action was begun. No kataphoric action, chemical absorption, cauterization, osmosis, softening, solution of continuity, melting down or anything else, has advanced the position of the bulb; which now, as before the operation, will with the gentlest touch drop into the canal below. It is this test, gentlemen, which has been going on before you this evening, only, that I have omitted the top slice of beef that the bulb and the galvanic action going on about it might be visible.

You may notice that the milliampere meter still registers six, and that the electrode is just where it was when you entered the room. It is a delicate experiment, and might have proved a false witness in this appellate court. Not that there was the slightest chance of the electrolytic action working a passage, for I have had the same result after using ten and fifteen milliamperes, but, if I have watched the electrode as a Damocles' sword, it

was because the difference between the supporting margins of the stricture and the weight of the electrode has been not less alarming than the size of the fabled thread.

To show you how little electrolysis need have done during this long seance, notice the same electrode passing by its weight alone through a piece of pulmonary artery perforated with the same punch, this tissue being a little thinner and more elastic than the aorta of the same animal.

As an excuse for making this experiment before you let me show by a quotation that the claimants have been in the habit of advancing their doctrine by this means. I especially refer to this lest they should now assume the attitude that no inference can be drawn from what we have seen, because of the dissimilar conditions existing in living and dead tissue. Dikeman says:

"In our text-books on electricity we find many given experiments for the decomposition of various substances by this agent. But we fail to find anything of a simple experiment by which any reference is made to demonstrate the utility of electrolysis in the treatment of organic stricture of the urethra, although much is said in favor of electrolysis in the successful treatment of morbid growths, tumors, chronic inflammations, etc.

I will attempt to demonstrate the principle of electrolysis on animal tissues. Take a small piece of fresh beefsteak and lay it on an insulated surface. Then with the positive electrode placed on the under surface of the beefsteak, and the negative electrode on its upper surface, where the decomposition can be watched, the conducting cords are now connected with six cells of the galvanic battery. By close observation in a few seconds the effects of the electrolysis on the tissues will be seen to take place. By continuing the experiment for a few minutes the results will be distinctly appreciable. Now when we treat stricture of the urethra by electrolysis we have just such an action taking place on the fibrous tissues of which a stricture band is composed. Yet some of the most eminent of our profession say the treatment has failed in their hands, and denounce the operation as unsuccessful."

Is it surprising that an investigator of such acute perceptions should have been unable to detect a single failure in his twenty-eight cases?

What are the gross appearances of these tissues which you have here seen so long in contact with the electrode?

The zone of glazed greenish gray tint surrounding the aper-

ture in the aorta contrasts clearly with the yellow color of the normal tissue beyond. A piece of tumeric paper applied to its centre gives a strong alkaline reaction. You may notice this affected zone is raised slightly above the general surface, this being most marked at the inner free margin of the zone where the electrode was in contact. Notice also the marked slipperiness of this zone when the nail or finger is drawn over it. The odor suggests ammoniacal urine. The puffy, œdematous infiltration, the alkaline reaction, odor, and the color, all suggest an increased rate of decomposition or putrefaction. I will not delay to suggest what the equivalents of this would have been in living tissues.

I cannot see that there is any change in the elasticity of the aorta tissue. If the same experiment is done with muscular tissue, where a bulb is used large enough to prevent its settling through the punched canal by gravitation, the gross changes are, briefly, a glazing of the parts as if gelatinized, an alteration in color from pinkish red to purplish red, and finally a condensed rigidity of the canal where the negative electrode has been in contact. Its loss of contractile elasticity being most apparent.

One important effect of the electric current when used upon the urethra in the manner under consideration and to which I have seen no allusion made, is that which it exerts as a self-feeding lubricant. The glands of Littre lining the whole membrane of the urethra whose ducts pass obliquely forward through the membrane, are normally active enough to fulfill their physiological purpose, but the mucus secreted is imperceptible. Under the influence, however, of galvanism, with the negative electrode in the urethra, this outpour of mucus is excessive; it is this which is seen collected on the shoulder of the bulb when withdrawn, and which Newman says is part of the dissolved stricture. The importance of this action has been overlooked. The marked softening of strictures felt, as the bulb is drawn to and fro over them, is in great part due to it. This mucus is rendered still more efficacious as a lubricant because of its saponification by the associated alkalies. When several strictures exist it is readily seen, that an instrument dipped in oil or smeared with vaseline, is well deprived of its mechanical aid, before the point has even engaged that part where the greatest resistance is to be encountered.

Besides the space thus gained by the emptying of these glands and follicles may be referred to as a slight but actual

increment in the equation between the dilatation the part is capable of and the size of the entering wedge.

For argument let us allow that a dense, organic, impassable stricture, wholly uninfluenced by any underlying muscular contraction, has been rendered passable by an instrument under the influence of electricity, used for the same length of time as a similar instrument tried just before but without electricity.

To what is this result ascribable? Shall we say with Burchard, Overall, and others, that vital activity in the stricture itself, or at its distal periphery, has resulted in such rapid physiological resorption, as to permit this necessary expansion? Can we, in the face of to-night's experiment, say that it is due to a melting down of the free surface of the stricture?

If such a stricture must be admitted passable, I believe it has been due to the mechanical influences of pressure materially aided by the lubrication just spoken of.

If the connective tissue, making up an organic stricture of the deep urethra, is absorbed by physiological processes stimulated by electricity, why should the same agent result in the additional deposit of connective tissue if used on a stricture at the anterior part of the same canal?

I am equally curious to know why a simple stricture of large calibre should be consigned by Belfield to urethrotomy, when, by inference from his statements, one would suppose a single electrolytic treatment should eradicate it. Is it perhaps, because, what little there is of this stricture is genuinely organic?

The majority of deep strictures respond more or less favorably to simple dilatation. They do the same if not better when the identical dilating instruments are used as negative electrodes.

The majority of anterior strictures do not respond so favorably to dilatation, and when electricity is added the results are apt to be unfavorable.

Do these facts point to some selective individuality in connective tissue formations, which prompt them to behave differently in different localities? Or do they afford reason to believe that the nature of these contractions is dissimilar? In other words, where in the deep urethra, we derive benefit from electric treatment, a spasmodic *element*, at least, has existed, whereas in the anterior portion harm has resulted, because we have had a purely organic obstruction.

From my own brief experience with electrolysis in cases of pure organic stricture I incline towards the conviction that this

agent, apart from the dilating effect of the instrument by which it is applied, is followed by no benefit.

I believe that a systematically conducted microscopic study of vegetable and animal tissues which have been acted upon by electrolysis, in the manner shown, will furnish facts of importance on this question. I had hoped to submit something of the sort in this article, but the time was insufficient. The inferences, from the hasty examinations I have made, are too vague to permit me to say more than, that, I presume a gradual urinary erosion may enlarge a stricture's calibre after a favorably adjusted galvanic current has produced a decomposition by chemical cauterization of its superficial layers, providing the same current has not acted upon the deeper parts of the stricture in effecting additional connective tissue deposit, and in a contracting condensation of that already existing. But that there is a *vis medicatrix naturæ* inherent in stricture tissue, the latent energy of which requires only to be put in motion by electricity when complete resorption goes on, I do not believe.

In fine, then, the only advantages this method can claim are:

1st. That it encourages patience and gentleness.

2d. That it furnishes two aids in overcoming spasmodic strictures, (a) lubrication, (b) an anæsthetizing influence upon the terminal nerves at the irritable point, and possibly earlier relaxation of spasm by muscular exhaustion following overstimulation; or, if the current is strong and long-continued, it may, as the electrode slowly passes, effect a moulding of the muscular envelope of the stricture, destroying its contractile elasticity and sealing this distention until again revived by natural processes.

3d. A slightly increased rate of exfoliation of hypertrophied epithelial masses.

4th. On theoretical grounds I would try it in cases of deep stricture of doubtful nature with urethral fistulæ.

5th. In certain cases, as a more or less permanent aid in those symptomatic affections, often of obscure origin, frequent and painful micturition.

Names of Operators and References.

No. of Cases.

Previous Treatment of different nature for relief of Stricture.

Location of Stricture and Nature of Stricture.

Calibre of Stricture.

Size and Nature of Negative Electrode.

Strength of Current.

Time in passing Stricture at One Operation.

No. of Treatments.

Average Time between Treatments.

Calibre of resulting Stricture when Treatment was discontinued.

Result; Subsequent History and Remarks.

All cases here reported have been graded to and expressed in the French scale of measurement.

Good deal of pain. Patient refused to continue treatment or be examined.  
Frequent micturition. Calibre of urethra increased three sizes.  
Some blood. Patient left hospital.  
Great pain during operation; twelve days later patient passed a cast of urethra. Refuse further treatment and left hospital.  
Some blood. Patient left hospital after a single treatment.  
Operation without much pain; Orchitis. Patient declared he was no better, refused further treatment or examination.  
Patient refused further treatment and left.  
Stricture at meatus contracted from 27 to 28. Refused further treatment.  
Stricture at meatus contracted from 26 to 14 Meatus incised to permit second treatment; contraction became steadily worse and urethrotomy was done.  
Two deepest strictures yielded to treatment; that at 1 inch became tighter.  
"Fail." "teen minutes; discontinued on account of pain. At second as; discontinued on account of pain at 4 1/2 stricture; after one week. At fifth treatment electrode was passed to bladder subsequent treatment with sounds.  
"Permanent cure."  
"Permanent cure."  
"Permanent cure."  
"28 French represented normal calibre of urethra."  
Well marked chill during night; on fifth day cast of urethra was passed; chill followed this treatment.  
28 French seems to have been the normal calibre of the urethra in nearly all of these patients, as they were discharged cured when such an instrument could be passed. Believes he is justified in claiming complete and radical cure.

KEYS  
New York  
Med. Jour.  
Vol. xiv, p.  
266, 1871.

FRANK.  
Med. Record,  
Vol. ix,  
p. 68.

BUTLER.  
N. Y. Medical Times,  
Vol. x, p. 268.

GLASS.  
Med. Record,  
Vol. xiii, p. 512.



# Result ; Subsequent History and Remarks.

All cases here reported have been graded to and expressed in the French scale of measurement.

Names of Operators and References.	No. of Cases.	Previous Treatment of different nature for relief of Stricture.	Location of Stricture.	Calibre of Strictures.	Sizes and Nature of Negative Electrode	Strength of Current.	Time in passing Strictures at first Operation.	No. of Treatments.	Average Time between Treatments.	Calibre of resulting Stricture when Treatment was discontinued.	Result ; Subsequent History and Remarks.
NEWMAN. Jour. of Amer. Med. Assoc. Vol. iv, p. 449, '98	100										All remained cured after from three and one-half to eleven years.
NEWMAN. Jour. of Amer. Med. Assoc. Vol. ix, p. 388, '97	100										All remained cured after from three months to five years.
DIXON. Med. Record, Vol. xiii, p. 678	1	No.	21 5 5 1/2	15. 3. 0.	9 Bulb.	6 Cells	Impassable	6	4 days.	28	After passing 5 inch stricture in eighteen minutes, he found another at 5 1/2 inches which was impassable ; at second operation he passed this stricture after nineteen minutes.
DIXON. Med. Record, Vol. xiv, p. 5...	3	No.	11	15	19 Bulb.	9 Cells		3	1 Week.	38	Author says if operation is conducted according to his directions every operator will be rewarded with success. He has treated twenty-eight cases without a single failure.
STREETER. Med. Record, Vol. xvi, p. 94.	4	No.	2 5	17 12	17 Bulb.	9 Cells		3	2 Weeks	36	In thirteen cases he used mild current and had no results ; in four of these same patients he used strong currents with bad effects. All were afterwards cut with immediate relief.
ANDERSON. Lancet, '85 Vol. ii, p. 1040	4	No.	2 5	28	Conica sound.	4-10 Cells.		5	10 Days.	34	This patient had made a false passage with a sound into rectum. Eighteen months after this single treatment he remains cured.
MAWSE. Cincinnati Clin. Soc. Vol. xvi, No. 7, p. 184	1	No.	11	26	Wire ring.	8 Cells	Impassable	1			One month after first treatment a No. 5 would not pass. Eight months after treatment was begun a No. 11 French could be passed. Author says so far no failures have occurred.
THOMAS. Acad. of Med. of Ireland, Vol. iv, p. 188	4	No.	5 1/2	0. 5.	Not stated.	18 Cells	15 Minutes	5	18 Days.		No progress was made after several attempts. Free effluence at meatus, mostly due to decomposition of mucus. Gleet discharge aggravated. Stricture was subsequently cut.
MORRIS. Brit. Med. Jour., '87, Vol. ii, p. 711	1	No.	5 1/2	0.	Not stated.	Not stated.	Impassable	1			After initial introductions of electrode ordinary sounds were used.
											Still under treatment at time of report.
											Still under treatment at time of report.
											This patient's stricture was impassable ; Author does not know the result of efforts.
											Fifteen days after treatment was begun all fistulae had closed and the induration surrounding them had been absorbed.

Names of Operators	No. of Cases	Previous Treatment of different nature for relief of Stricture.	Location of Stricture and Nature of.	Calibre of Strictures.	Size and Nature of Negative Electrode	Strength of Current.	Average Time between Treatments.	Calibre of resulting Stricture when Treatment was discontinued.	Result; Subsequent History and Remarks.
PRINCE. Trans. of Amer. Surg. Assoc. Vol. iv, p. 334, '86	1-	No.....	Not stated.	Impassable by ordinary means	Holt's Dilator....	Strong enough to be sharply felt at positive sponge Electrode	Week.....	.....	After passage of Holt's Dilator the treatment was continued with ordinary sounds used as negative electrodes.
STEVENSON and BRUCE CLARK. Proced. of Royal Med. and Chir. Soc., '86, No. 13 (Vol. ii, No. 3)....	1-	Cannot find details.....	1 1/2 4 5.....	4.....	3 Bulb.....	5-8 Milli-Ham.....	.....	20 sound	Author says whether this method can effect a cure or not time alone can show.
EDWARDS. Ibid.....	1-	Successfully by gradual dilatation then a relapse.....	2 1/2.....	19..... A Nodule of cicatricial tissue on one side of Urethra seen by Endo-scope.....	A Negative Electrode in form of needle punctured the Endo-Nodule..	Guided by sensations of patient	.....	.....	Immediately after first treatment an instrument one millimeter larger could be passed; viz. 20. The stricture finally admitted only a 16. and it was widened by other means.
HILL. Ibid.....	1-	.....	1 2 3 1/2.....	19. 19. 16.....	20.....	4 Milliampere.....	1.....	.....	Chill, vomiting, etc., twelve hours later. Had had chills before after passage of sounds.
ALLAN. Boston Med. and Surg. Jour. Vol. 117, p. 621, '87.	4-	1 No..... 2 No..... 3 No..... 4 No.....	1 1/2 1 1/2..... 1 1/2 2 1/2..... 1 1/2 3 1/2..... 1 1/2 3 1/2.....	17..... 23. 18. 14..... 25 11. 11.....	18..... 20..... 15.....	4 Milliampere..... 4 Milliampere..... 4 Milliampere.....	1..... 1..... 5..... 1.....	..... 14..... 20..... .....	Malaise and copious discharge. Stricture found to have contracted and treatment abandoned. Local irritation; at fifth treatment patient became faint after 25. electrode had been in contact with first stricture for fifteen minutes. Treatment discontinued. Treatment abandoned owing to faintness and resorted to gradual dilatation.
WOLFF. New Yorker Med. Press 1891-2, iii, 131	2-	Gradual dilatation had no effect..... Hot baths, 2 in. Penile Morphine, etc.....	1 1/2..... 3 in. Penile Morphine, etc.....	Not stated..... Impermeable.....	3..... 1.....	3-5 Elements..... 5-10 Elements.....	..... 6.....	N't stated..... N't stated.....	After 18. had entered bladder he completed treatment by simple dilatation up to 20. and discharged cured. Has had no return for eleven months; after first electrode was passed, completed treatment with steel sounds. Patient still under treatment.

# Result ; Subsequent History and Remarks.

All cases here reported have been graded to and expressed in the French scale of measurement.

Names of Operators.	No. of Cases.	Previous Treatment by same Operator for relief of Stricture.	Location of Strictures and Nature of.	Calibre of Strictures.	Sizes and Nature of Negative Electrode	Strength of Current.	Time in passing Strictures at first Operation.	No. of Treatments.	Average Time between Treatments.	Calibre of resulting Stricture when Treatment was discontinued.	Result ; Subsequent History and Remarks.
Bayer. The South- ern Clinic, Vol. vii., p. 33, '94.	1	No.	6.	Not stated.	16.	Not stated.	Not stated.	2	N't stat- ed.	21	" As this is the normal calibre of the urethra, patient discharged cured."
	2	No.	4.	15.	17.	9 Cells.	11 Minutes	4	N't stat- ed.	21	" As this is the normal calibre of the urethra, patient discharged cured."
	3	No.	4 6.	8.	15.	Not stated.	Impassable	4	N't stat- ed.	21	" As this is the normal calibre of the urethra, patient discharged cured."
BORGARD The Medi- cal Record, Vol. xxiii., p. 655, '88.	1	No.	M. 2 5 1/2.	14, 12, 17.	14.	6 Cells.	In 15 Min- utes passed 2 in stric- ture.	10	1 Week.		Two months later there was no appreciable contraction along the canal.
	2	No.	M. to 5 1/2.	6 will pass all.	5.	10 Cells.	8 Minutes	5	1 Week.		Night after first operation patient had retention. Catheterization was performed with great difficulty. Six months later 23. Bougie-a-bout detects no obstruction.
	3	Yes; Gradual dilatation with sounds at the first treat- ment from 1 to 15 Meatus admits 24.	4 1/2 4 1/2 5. Organic and Spas- modic.	15.	16.	5 Milliam- peres.	8 Minutes	7	1 Week.	24	Two months later 23. Bulb passes, detecting very faint trace of any strictures but those at 4 and 4 1/2.
BROWN.	2	No ; Meatus admits 24.	1 1/2 1 1/2 2 1/2 Organic.	18, 18, 18, 18. 16, 18.	18.	4-7 Milli- amperes.	18 Minutes	5	1 Week.	15	Strictures were tighter at each visit ; six weeks after all treatment had been discontinued 13 admits only 11 ; 2 1/2 admits only 10.
	3	Meatus ad- mits 24.	4 1/2 6 1/2. Spasmodic, dependent upon irri- table an- terior Urethra.	27 refused. 24 passes with.	5 Milli- amperes.	8 Minutes	8 Minutes	3	1 Week.	26	Marked improvement in functions of bladder and urethra, but no permanent gain in calibre of strictures.
	4	Yes, sounds with tem- porary bene- fit to symp- toms. Me- atus admits 34.	4 1/2 6 1/2. Spasmodic, due to sym- ptoms. Me- atus admits 34.	80, 28, 32.	4 1/2 Milli- amperes.	8 Minutes	8 Minutes	5	1 Week.		Relief to symptoms followed first operation, these returned after third treatment, and were not again dissipated by its continuance.
BROWN.	5	Yes, sounds no gain be- yond 23. Meatus ad- mits 28.	2 1/2 3 1/2. Organic.	24, 23.	24.	3-5 Milli- amperes.	2 Minutes	5	1 Week.	23	The same Bulb as that with which treatment was begun can still be passed, but with greater difficulty. An occasional symptom viz. slight involuntary dribbling, was benefited after second treatment, but returned in an aggravated form after the fourth.
	6	Yes, sounds with no ben- efit. Mea- tus admits 38.	6 1/2 7. Spasmodic, due to Cystitis.	19, 18.	21.	4 Milli- amperes.	5 Minutes	3	6 Days.		Treatment very painful ; may have been due to bulbous shape of instruments. After first treatment several symptoms benefited, but complete relapse three days later. Pain obliged discontinuance of this method. No gain of calibre during nor long after treatment.

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## Society Transactions.

### THE NEW YORK DERMATOLOGICAL SOCIETY.

THE 182D REGULAR MEETING.

DR. R. H. TAYLOR, *President, in the Chair.*

DR. SHERWELL presented a case of

#### ONYCHO-ATROPHIA.

Mrs. B. K—, *et 55*, a widow and a native of Ireland, states that about two years ago she had an eruption apparently of eczematous nature appear on both legs below the knees. It was unattended with much itching or other subjective symptoms and has gradually spread since that time, forming large, scaly, and verrucous patches. Coincidentally with the appearance of the eruption, the nails on both feet commenced to thicken at the base, their nutrition became affected, and gradually their complete loss has ensued. The patient's general health had been very good up to within the last few years and she still looks fairly well nourished; but for the last two or three years she has complained of general lassitude and disinclination to exertion. She has also complained at various times of rheumatism, or perhaps rather, of neuralgic symptoms. There is no evidence to be obtained of any specific or other diathesis. Her urine has been examined for sugar with a negative result and no other morbid condition was found. Doctor Sherwell could give no other title to the disease, than onycho-atrophia from some obscure nervous cause.

DR. BULKLEY presented a case of

#### ACUTE LUPUS ERYTHEMATOSUS.

E. S—, *et 19*, born in Ireland, is a housemaid and has always been in good health. She first noticed, in the middle of January of this year a few little reddish pimples just under the inner canthus of the left eye. The blotches were like those seen on the face at present. They gradually spread over the eyelids and appeared also in front of left ear and afterwards behind it. The disease developed about the lips and then gradually over the entire face. The patient has never had any other eruption on the skin, there is no history of syphilis. Her menstruation has been irregular and her bowels costive during the last few months. She has been under treatment in Jersey City, having used *sapo viridis* and ointments, and has also taken Fowler's solution, in doses of *gtt ii* three times daily. Her condition at present is as bad as it has ever been. The eruption has been itchy but now only burns.

In the discussion, Dr. Fox said that it reminded him of a case which he had shown some five or six years ago to the Society. It had been thought to

be an erythema and the diagnosis of lupus had been doubted. The development of the patches had, however, gone on until the appearances were typical of lupus erythematosus.

DR. BULKLEY said that the acuteness of the outbreak was very interesting and that he had never seen the disease situated on the entire eyelids. He had lately a case in a child ten years of age in whom the development had been almost as acute as in the patient presented to-night. The disease in the child consisted of patches on the nose, face and scalp.

DR. ELLIOT asked Dr. Bulkley if in designating the cases as acute lupus erythematosus, he meant that they were acute in the sense that Kaposi did when he reported those cases of lupus erythematosus characterized by rapid dissemination, general severe systemic disturbance and death.

DR. BULKLEY said that he used the term acute for the cases he spoke of, only on account of the rapid development of the lesions and without intending to compare them with the lupus erythematosus acutus of Kaposi.

DR. CAMPBELL presented a

#### CASE FOR DIAGNOSIS.

Mrs. S—, æt 55, has had the present eruption for over six months. When she was first seen last December, the affection occupied the whole of the left leg, being made up of circular patches with well defined margins. These varied in size from a quarter of an inch to three inches in diameter. They were red, scaly and slightly moist. At present, the whole of the leg from about an inch below the knee, and extending a short distance on the foot, is covered with a red, dry and scaly eruption. On the foot are two or three patches about half an inch in diameter. Both above and below, the eruption terminates abruptly and has a well defined margin. The patient's general health is good.

In the discussion Dr. Allen said that he would consider the case as one of eczema.

DR. FOX said he regarded it as a seborrhoic eczema in nature, which often beginning on the chest or other parts of the body appeared as circumscribed, quite sharply limited patches.

DR. ELLIOT said he considered it to be a case of eczema seborrhoicum as described by Unna. He had had within the last seven or eight months a very large number of such cases and he had found that in their development, course and response to treatment, they agreed very accurately with Unna's description.

DR. KLOTZ presented a case of

#### DISEASE OF THE NAILS.

John S—, æt 49, a framer and carpenter by trade, is married and the father of four children. He has always been in good health. He had been a soldier in the Prussian army and had served in the wars of 1864, 1866 and 1870. He came to America five years ago.

Four years ago in August, while lying quietly on a lounge, he was suddenly taken with a spell of unconsciousness accompanied by slight distortions of the face. This lasted but a very little while, but a slight dizziness remained for some time. These spells, which seemed to bear every resemblance to attacks of "petit mal," returned at rather long intervals for several years, sometimes ceasing for several months, especially under the use of bromide of potash. Of late he has not been subject to the attacks, except infrequently, although he has given up the medicine. About nine weeks ago the present disease of the nails began to make its appearance, first on

the fifth finger of the right hand, where the skin became red and discharged a watery fluid. The disease soon progressed and attacked all the fingers, except the fourth finger of both hands, which has remained unaffected. On the fifth finger of the right hand, the nail has come off entirely and a new one of not very healthy structure has grown in its place. The other nails all show different stages of disease. They are discolored, their surfaces uneven, owing to deep transverse furrows, and the portions nearer the proximal ends are thin and rough. The whole nail substance is soft and fragile. The surrounding skin is somewhat swollen and red, showing in some places the traces of superficial erosions, which had caused considerable pain, burning and itching.

The patient applied for treatment at the German Dispensary last Saturday, the 19th of May. Dr. Buchler who saw the patient during my absence, prescribed the five per cent. compound salicylated soap plaster and to-day found the condition of the nails and of the surrounding skin much improved. The patient himself was also very well satisfied with the effect of the plaster. He has applied it in a very skillful manner and is able to use his fingers to a certain extent.

DR. KLOTZ believed that the affection was an eczematous process affecting the finger tips and the matrix of the nails. The absence of every trace of disease on the fourth finger of both hands was, however, certainly very remarkable and the distribution of the nerves could not very well account for this selection.

DR. FOX thought there was some onychia, but there were no evidences of eczema.

DR. SHERWELL thought that the exclusion of the fourth finger suggested some neurosis.

In summing up, Dr. Klotz stated that he considered the changes in the nail and on the skin in the vicinity of the nails were due to the same process. The absence of itching was peculiar.

DR. FOX presented a case of

#### LICHEN RUBER WITH MONILEFORM LESIONS,

in a young man aged 22, who gave the following history : The disease is said to have begun at the age of 8 months, after an attack of variola, the scars of which are plainly seen upon the patient's face. He is thin, though in fair health, and the skin is everywhere of a brownish tinge. The primary lesions are small acuminate papules of a dull red hue, and when closely aggregated they show a tendency to become surmounted by minute white scales. Upon the back of the neck the isolated lesions can be most distinctly seen, while about the wrists they have coalesced and the skin appears thickened, dark and rough. The hands are notably deformed by the eruption. The skin is harsh and shriveled, contracted upon the palms and swollen about the finger joints. Upon the buttocks there are large white patches, produced by numerous scale-tipped papules, and in each popliteal space there are two small, scaly patches situated over the tendons. Asking the patient to bend forward while keeping the knees stiff, Dr. Fox called attention to the peculiar localization of the papules and to the perfect resemblance of the eruption in this case to the plate of lichen ruber in the last edition of his "Photographic Illustrations of Skin Diseases." Upon the flexor aspect of each elbow joint the monileform or beadlike arrangement of the lesions was exceedingly



well marked, the papules forming a number of long, scaly ridges. These appeared to meet or cross each other in the centre, and the impression was conveyed that at some time the skin in this locality must have been deeply scratched. In connection with this picture of the case, Dr. Fox exhibited a plate of lichen ruber monileformis from "Neumann's Atlas."

In the discussion, Dr. Morrow said that he thought the lesions on the back of the neck resembled lichen planus. He thinks, however, that there is a difference between lichen planus and lichen ruber, and that this case is one of lichen ruber monileformis.

DR. BRONSON said he saw nothing like lichen planus present, but would consider it (the case) to be one of lichen acuminatus.

DR. PIFFARD considered the case to be one of lichen ruber, having no resemblance whatever to lichen planus.

DR. SHERWELL stated that it resembled very much a case presented by him some years ago to the Society. He would call attention to the absence of fat, which is seen in these cases of lichen ruber. There seemed to be a malaric condition of the skin present in all of them.

DR. KLOTZ said that he considered the case to be an example of lichen ruber acuminatus and lichen planus, occurring in the same patient at the same time. The patch on the back of the neck was distinctly composed of planus lesions.

DR. ELLIOT said that he also regarded the case as one of lichen acuminatus and lichen planus mixed. The case resembled the one reported by Kaposi, as lichen ruber planus monileformis. On the flexor surfaces of the arms at the bend of the elbow, and on the back of the neck there were distinct planus lesions. The lesions composing the patches mentioned were of all sizes, some as large as a pea, and he could not make that fact fit into the description of lichen acuminatus, in which the lesions have always been described as pin-head size, never enlarging, but remaining during their entire existence of the same size. He thought that lichen acuminatus and lichen planus were only different forms of the same disease, lichen ruber, and could imagine no reason why they should not exist on the same patient as, in fact, had already been repeatedly described.

DR. PIFFARD stated that there could not possibly be any connection between lichen ruber and lichen planus. The fourteen cases upon which Hebra based the description of the disease, lichen ruber, were totally distinct from the lichen planus of Wilson. Besides, in the first edition of Hebra's book there was no mention of the lichen planus, but in the second edition, which appeared after Wilson's description of fifty cases, the disease was calmly appropriated and made a form of lichen ruber. In his opinion, they were two entirely distinct and separate diseases.

DR. TAYLOR said that in connection with the remarks of Dr. Piffard, he would state that the inclusion of lichen planus in the lichen ruber of Hebra was done by Kaposi in the second edition of Hebra's book, but only after he (Dr. Taylor) had published the history of a patient, Kane by name, in whom the development of one of the diseases after the other had been observed. He considered lichen planus absolutely distinct from lichen ruber.

DR. PIFFARD here moved that a vote of the Society be taken as to whether lichen planus and lichen ruber were distinct forms of disease or only varieties of the same disease.

The motion having been put to the Society by the President, the vote resulted as follows :

Drs. Bronson, Bulkley, Campbell, Cutler, Fox, Jackson, Keyes, Morrow,

Piffard, Sherrell, Taylor, Weisse, Fuller and Allen, held that they were two distinct and separate diseases.

Drs. Elliot and Klotz were of the opinion that lichen planus and lichen acuminatus were varieties of one disease, lichen ruber.

DR. ALLEN presented a case of

#### CHANCRE OF THE UPPER LIP

the size of a ten cent piece, having a prominent border and an ulcerating base, which was only slightly indurated. The patient was an unmarried woman, Miss M. B., 28 years of age. She came under treatment for the first time on May 4th, after the sore had already existed for three weeks. Although the lesion has been present for nearly six weeks, there are not yet any glandular enlargements to speak of, nor has any eruption made its appearance.

The patient promised to send her lover for examination, though she says he is well, but he has not yet come. There is no history in regard to the source of infection. The sore itself began as a small papule, which, becoming as large as a ten cent piece, ulcerated. The treatment has been non-specific, consisting of soothing and antiseptic ointments locally and mist. rhei at sodae internally.

DR. FOX stated that he would hesitate in making a diagnosis under the conditions, because he had seen several lesions similar to this one which had disappeared and no syphilis had developed.

DR. KEYES did not think the diagnosis of syphilis in the case was a certain one. There should be a greater induration of the glands in the sixth week. The ulcer was not a typical one. The lesion might be a soft chancre.

DR. MORROW thought that the induration of the lip was quite characteristic, but that of the glands was not.

DR. TAYLOR said that syphilitic chancres were either very hard or soft. Sometimes the induration was insignificant and sometimes not, and much of the induration is lost when the tissue breaks down, owing to the constriction of the blood-vessels, and an ulcer is formed.

DR. ALLEN said, in summing up, that the patient had not been placed on specific treatment. He had waited for a confirmation of the diagnosis from the future symptoms. He thought, however, that it was a syphilitic chancre.

DR. BRONSON presented a case of

#### ANGIONEUROTIC DISEASE,

characterized by recurrent attacks of erythema with marked oedematous effusion. The patient was a dressmaker, 28 years of age. Her general health had always been good, with no rheumatic or other diathetic troubles so far as could be ascertained, until last August, when there appeared an eruption of red itching papules on the inner surfaces of both wrists. The remains of the eruption were observed, when the patient came to Dr. Bronson in March, 1888, and had the appearance of lichen planus, though not very well marked. In addition to the eruption, the patient complained of a recurrent exanthem, which occurred at frequent intervals on various portions of the body. It had been first noticed in December, 1887 and consisted of red or pale elevated spots, which varied in size from that of a twenty-five cent piece to that of a table plate. The efflorescences were attended with great irritation, coming

on slowly, usually toward the latter part of the day and lasting for several hours (from twelve to fourteen or sometimes twenty-four hours), and disappearing gradually. The same attacks still continue, coming on at frequent intervals and in varying severity. Rarely a day passes without more or less of an attack. The color of the eruption is sometimes red or crimson and sometimes of a dark purplish hue, sometimes there is but little alteration in color, but merely a circumscribed swelling. The swellings are sometimes of great size—as large as a flattened orange. Once a swelling occurred at night on the side, and the patient states she could not cover it with her two hands. Not long ago, the entire cheek became swollen and hard, the induration being situated especially in the centre. When the patient was seen by Dr. Bronson after this attack, and as was usually the case, the swelling had subsided, and only the outlines and a slight reddish or dusky discoloration could be perceived. The swellings pit on pressure, and when seen have always been rather soft. They seem to occur most frequently on the face and forehead, but also often on other parts of the body. The patient is exceedingly nervous and despondent. The itching of the swelling often keeps her awake at night. She complains of frequent headaches and often of dizziness. Occasionally she has had slight bleeding from the nose in the morning. The appetite is very poor, and the tongue often deeply furred.

In the discussion Dr. Klotz stated that he thought the case was one of the acute angioneurotic oedema first described by Quinque.

DR. ELLIOT also would regard it as belonging to that form of disease. It agreed with the cases lately described by Riehl, Osler, etc., in its general features, and also with a case described by himself in the January Number of the *Journal of Cutaneous and Venereal Diseases*, though the subjective sensations were much more marked than usual. As far as he knew, only one case had been cured, that of Matas, though others had been relieved.

DR. FOX presented a case

#### FOR DIAGNOSIS.

The patient a stout German was 45 years of age and in good health. The trunk was covered with lenticular papules varying in color from a yellowish brown to a purplish red, but disappearing under pressure. There was no itching or other subjective sensation. The eruption looked very much like an ordinary papular syphilide, but was chronic, having begun on the left side five years ago and gradually spread until recently, when there had been a marked increase in the extent of the eruption.

The Society then went into Executive Session.

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## Selections.

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### ALTERATIONS OF THE SKIN WHICH ARE PRODUCED AT THE TIME OF PUBERTY AND AT THE MENOPAUSE.

It is well known that the physiological changes which take place in women at the time of puberty and at the menopause have an evident influence upon the development of certain affections and alterations of the skin. The influence of the menopause has been well studied by Danlos and by

Barié, but that of puberty has been somewhat neglected, although it presents a certain interest.

We often see produced at these two epochs of a woman's life, hyperidrosis, erythemas, eczemas, acne, erysipelas, and more rarely urticaria and furuncles. Pruritus and pigmentary hypertrophies are also met with. Let us pass in review those alterations of the skin.

### I. Hyperidrosis.

This is frequently seen at the menopause, more rarely at puberty ; it may be local or general. Local hyperidrosis is ordinarily found upon the face ; flashes of heat occur suddenly, the face becomes red, turgescient, and becomes covered with an abundant hot sweat. In some cases it is cold. Localized sweating may exist on other regions of the body, notably upon the chest and thighs. Generalized sweating is quite frequent. In some cases the heat is preceded by a slight shivering and a sensation of swooning. Danlos (*Thèse de Paris*, 1874) cited the case of a seamstress who, in the midst of her work, suddenly began to perspire freely in the face, upon the thighs, and about the waist. This was preceded by heat, lassitude, vague pains in the limbs, and roaring in the ears. In 1879 I saw a woman of 46 years, whose menses were very irregular and incomplete, who suffered from cephalalgia and cramps in the limbs, and who each night awoke between two and four o'clock bathed in perspiration. In another case the hyperidrosis was localized upon the shoulders and in the axillæ, and in still another upon the hands. In one case upon the face in a woman of 51 years, which began two months after the cessation of the menses, it lasted eighteen months, and appeared from a single time to eight times a day. It may come at any time of the twenty-four hours, and has been known to occur as often as 48 times. Liégeois (*Rev. Med. de l'Est.*, Vol. XI.) has seen a hyperidrosis last two years. I have seen a patient who for eleven years had cold sweats localized about the waist, abdomen and thighs, and coming on regularly each month. Levy relates a case of which we have seen the counterpart. A woman of 28 had local perspiration of the chest at the beginning of each menstrual epoch.

Authors do not mention hyperidrosis at puberty. I have seen two cases. In one, a girl of 15, who had suffered several attacks of eczema in her infancy, menstruated once and not again for about a year. During this interval every four or five days she had an abundant perspiration of the chest and axillæ, with a penetrating odor and the subsequent production of a papular eczema. With the re-establishment of the menstrual flow, the hyperidrosis and eczema both disappeared. In the second case, a girl of 13, with painful menstruation, had at each period flashes of heat followed by abundant perspiration of the chest and face.

### II. Erythemas.

When abundant sweats occur in certain regions they frequently produce simple erythemas which disappear with a little care. Erythematous patches appear upon the face, neck, etc., which rapidly disappear—*erythema fugax*. These are also occasionally called forth by moral emotions and have been attributed to vasomotor troubles. Erythemas are also produced without emotional cause, they follow the heat flashes, are more intense and may become the starting point of rosacea. The same thing is

seen in chlorotic and hysterical girls at the time of puberty. There may be no hyperidrosis but only sudden facial congestion.

### III. Eczema.

Beside the eczema of hyperidrosis there is often seen at the time of the menopause an outbreak of eczema upon various regions of the body either for the first time, or as a recurrence of an eczema which had previously existed.

It is especially in arthritics that this occurrence is frequent. We have seen patients in whom the first attack was at puberty and the second at the menopause. The eczema often appears upon the ears, scalp, face and feet, but eczema of the genitals is specially observed at the critical age. It begins upon the labia majora and spreads to the neighboring parts. In certain rare cases it also affects the anterior portion of the vagina. It is very severe on account of the great itching. It has evening exacerbations, and the itching is not less than in pruritus, an affection which by the way it often succeeds. While we quite often see an eczema appear with the first menstruation we also occasionally see a previously existing eczema get well at this time. Several such instances are cited.

### IV. Acne Rosacea.

All dermatologists agree that acne vulgaris and acne rosacea are frequent at puberty. According to Kaposi, at the same time that the hairy system takes on more active development, the functions of the sebaceous glands are increased, and under these conditions acne is produced, according to his observations, more often in brunettes than in blondes. Bazin says the miliary form is often seen at this time characterized by small white pearly granular lesions, but the indurated form is also frequent. Acne rosacea is also especially noticeable according to Kaposi in young chlorotic girls at this time. Hardy writes that acne disappears at times in young women after marriage, and attributed a certain influence to continence in the production of inflammatory acne. When acne exists before the menopause, even in a light degree it is pretty constantly aggravated. We have seen cases of indurated acne become hypertrophic at this time. Hardy has seen acne rosacea begin almost constantly before the cessation of the menses, and the menopause seems to him rather to aggravate the condition than to cause it. While rosacea frequently follows dyspepsia, hepatic and uterine affections, etc., there are also cases closely associated with the menopause following congestion, flashes of heat and erythema.

### V. Pemphigus.

Dr. Jackson Cummins in the *Brit. Med. Journ.*, 1884, reported the case of a woman very hysterical, who suffered at the approach of the menopause, a series of outbreaks of pemphigus. The bullæ appeared upon various portions of the body and caused severe pain. At the same time that the fluid discharge was abundant from the bullæ, there was noticed a profuse discharge of fluid from the vagina which was discovered not to be urine. Dr. Cummins thought it quite probable that there was an eruption of pemphigus upon the mucous membrane of the vagina and perhaps of the uterus. This seemed to the writer more of the nature of pemphigus hystericus, than a pemphigus due to the menopause. Professor Hardy has given the name of pem-

phigus of young girls (*pemphigus virginum*) to a bullous eruption which is produced by successive eruptions extending over several months, and which he has met with only in girls from 14 to 20 in whom menstruation had been interrupted.

### VI. Pruritus.

There is always at the time of menstruation a slight pruritus of the vulva with a feeling of heat and tension. This may be exaggerated at the time of the first "show" but this is only to be looked for in excessively nervous girls, with painful menstruation, congestion and turgescence of the genitals. We have seen a case in which a quite intense and constant pruritus preceded the flow by some four or five days. Both small and large lips were much congested, and upon the labia minora were dark red spots. All symptoms disappeared as soon as the flow of blood began. Vulvar and vulvo-vaginal pruritus are commonly encountered at the menopause, it varies greatly in degree, some cases being so severe that I have seen patients rub the parts with stiff brushes, or roll upon the floor screaming with pain. It occurs in crises, most often after the patient is in bed, and this because of the change of temperature. The length of attack varies from fifteen or twenty minutes an hour or more, and several attacks may come on during the night. In vulvo-vaginal pruritus the pains are violent and according to some patients enervating. When there is a coincident discharge from the vagina, the pruritus is more easily relieved. Scratching often causes eczematous lesions. In such cases the itching becomes more bearable, but once the eczema is cured the pruritus returns nearly always in its original form. Pruritus is often accompanied the genital form. In some the duration is not over six months, in others it lasts one or two years. In such cases the health suffers, nervous troubles come on with loss of appetite and of weight.

Diabetes must always be suspected. This is also true of eczema, and it must be excluded before a diagnosis of menopause affection is made.

### VII. Urticaria—Furuncle—Onyxia.

The connection of urticaria with the sexual apparatus is well known. It only rarely occurs from puberty to the critical age. All authors mention the incontestable influence of uterine affections, but say nothing of these two phases of physiological evolution. Francotte says that furuncular eruptions have been noted by many observers at the time of the menopause, but from what we know of the pathogeny of furuncle we cannot attribute it directly to the menopause. As to the cases of onyxia cited by Tilt, in which some patients would experience severe pains in the finger nails, while others would have complete shedding of the nails, it would be necessary to know if there were not a gouty element present.

### VIII. Pigmentary Hypertrophies.

Pruritus and its consequent scratching often produce at the periods of puberty and the menopause, especially the latter, hypertrophies of pigment especially about the genitals following idiopathic pruritus without cutaneous lesions. It is the consequence of repeated hyperæmia in a marked degree, of the capillary vessels. After eczema of the genitals a passing pigmentation is also often left behind. Rayer and others have noted the singular fact of a black or bluish coloration of the skin in cases of sud-

den appearance of the menopause. A case of dyschromia, of the whole skin was observed by Lyons of Dublin and cited by Barié (*Gaz. des Hôpitaux* 1858). The patient was obliged to bathe over twenty times a day. Lyons attributes the phenomenon to an excretion of pigment. It is generally admitted that chromidrosis appears at the approach of the menses, under the influence of menstruation and at the time of the menopause as well as during pregnancy.

### IX. Erysipelas.

Many authors have cited cases of erysipelas at the moment of menstrual cessation. Tissot reports a case in which erysipelas occurred fifteen times during the two years succeeding the menopause. They became less frequent in the third and fourth years, and in the fifth there was but a single attack. Behier observed a woman of 54 in whom the monthly flow was replaced at correspondingly regular intervals by erysipelas of the face, usually attended with coma. Numerous cases have also been reported at the time of puberty. These cases are sufficiently explained by the many ports of entry open to the microbes at this time after the rupture of the vessels, by fissures, excoriations, and results of scratching.

Such then is the picture of cutaneous alterations at puberty and at the menopause. Furuncles and erysipelas are accidental, but the other affections considered are found especially in women with constitutional predisposition (rheumatism and gout) which favor the outbreak of cutaneous troubles. In the eruptions at puberty, chlorosis and hysteria come in for a large share of blame. Dr. L. Deligny, *La Concourse Medical*, April 14, 1888.

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## Book Review.

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A PRACTICAL TREATISE ON DISEASES OF THE SKIN. By James Nevins Hyde, A.M., M.D. Professor of Skin and Venereal Diseases, Rush Medical College. Chicago, etc.

This book is so well and favorably known to the medical profession that it requires no further commendation from the pen of the medical reviewer.

In this—the second—edition, Dr. Hyde has conformed to the classification and nomenclature of diseases of the skin adopted by the American Dermatological Association which has involved a labor which adds largely to the worth of the book. New chapters have been devoted to the description of several cutaneous diseases whose names were unknown a few years ago; other chapters have been entirely rewritten. In all nearly one hundred pages have been added, together with a number of new and admirably executed wood cuts and two portraits of rare skin diseases in colored plates.

For a review of its scientific merits we refer to Vol. I 1882 3 pp. 285 of this Journal.

As a concise record of results of observation of over ten thousand cases, emanating from a skillful and accurate observer, and embodying at the same time the well digested results of the observation of others, this volume must commend itself to all.

## Items.

**TREATMENT OF LEPRA.**—Bidenkap (*Deutsche Med. Zeit.*, No. 100, 1887) has only seen one case of leprosy benefited by Unna's ammonium sulpho-ichthyolicum out of many on which it has been tried, and according to his observation, the following is the best formula for local treatment. It is spread thickly and applied for thirty-six to forty-eight hours. Every eight to fourteen days :

R. Olei Olivarum.....	20 pts.
Resinæ Colophonii.....	20 "
Ceræ flavæ.....	40 "

Melt over a water bath for half an hour, with constant stirring. Cool and add the following mixture :

R. Gummi resinæ ammoniaci.....	2 pts.
Balsami Terebinth, venetæ.....	2 "
Chrysarobini.....	12 "

**UNDESCRIBED CUTANEOUS SYPHILIDE.**—Dr. Salsotto describes *Giornale Italiana delle Mal. Ven. e dell Pelle*, Oct. 1887) what he designates : "A cutaneous syphilide not hitherto described." His conclusions are :

1. There exists a special primitive form of papulo-squamous syphilide of the face, which has its seat upon the cheek, the lip, the ala of the nose and the chin.

2. It always appears in the secondary period of syphilis, and for the most part in the first year of infection.

3. It does not give way readily to specific treatment, has a relatively long duration, and the consecutive pigmentary macules are persistent.

4. Recurrences are often seen, the form remaining the same, and occupying the same situations.

5. From these data this papulo-squamous syphilide may be compared to plantar and palmar psoriasis.

**ITCH OINTMENT.**—Fournier gives the following (*Gaz. Méd. de Nantes*) :

Flowers of sulphur.....	50 grams.
Powdered carbonate of soda.....	25 "
Gum tragacanth.....	0.50 centigrams.
Glycerin.....	100 grams.
Essence of any kind.....	9.5. "

The body is first to be washed with soap, followed at once by a bran bath. Then the pommade is to be rubbed in. This is followed by another bath. The following day, glycerole of starch is to be applied after emollient baths.

**SUCCESSFUL TRANSPLANTATION.**—Salzer showed a patient who had been operated upon, first in 1886, in Billroth's clinic, for a tuberculosis verrucosa cutis of the palm, following an injury of the forefinger some four years previously. Contraction had taken place to such an extent in the scar that the man could not work. Salzer therefore removed the whole mass of cicatricial tissue and replaced it with a piece of skin from the patient's hip, with a favorable result.—*Viertelj. für Derm. und Syph.*, No. 2, 1888.



JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

SEPTEMBER, 1888.

No. 9

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**Original Communications.**

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**DERMATOLOGICAL NOTES.**

ACUTE MULTIPLE SYMMETRICAL GANGRENE; RELAPSING  
DOUBLE ZOSTER; BULLOUS ERUPTION DUE TO QUINIA;  
LICHEN RUBER PLANUS; LICHEN RUBER ACUMIN-  
ATUS; PAPILLOMA ANI, PERINEI ET PENIS  
POST ECZEMA CHRONICUM; EARLY  
RUPIA IN SYPHILIS.

BY

GEORGE T. ELLIOT, M.D.

Dermatologist to Demilt Dispensary, Assistant Visiting Physician New York Skin and  
Cancer Hospital, Member of the New York Dermatological Society, etc.

**I. ACUTE MULTIPLE SYMMETRICAL GANGRENE.**

THE patient, a male æt. 23, of German parentage, came to my office on December 8, 1886. He was of average height, muscular and accustomed to work of all kinds, though not to any requiring great or protracted exertion. His health had always been perfect and he can give no history of any previous general disease or of any eruption upon the skin. His physiological functions were normal and examination did not reveal the existence of either Bright's disease or of diabetes. The patient stated that on December 4th, he carried a very heavy and unwieldy object down two flights of stairs and on December 6th, he shoveled snow from the sidewalk for several hours and also worked in a cellar lifting heavy

objects. He was excessively fatigued after this work, but only on December 7th, in the evening, did he observe any lesions. They were three or four in number on each buttock immediately over the acetabula, and varied in size from a pin-head to a pea. They were not painful, were circular, dry and of a black or grayish-black color and were bounded by a slightly elevated, red border. During the night of the 7th and the morning of the 8th, new spots appeared symmetrically on both buttocks and the earlier ones increased in size. The history, which he gave, was very accurate, owing to his having closely watched the symptoms. He denied absolutely that the black spots were preceded by any other form of cutaneous lesion, as for instance a vesicle or redness, and also stated that there was an entire absence of subjective sensations.

When an examination was made, it was found that on the right buttock, there were twenty-five and on the left buttock twenty-eight of these lesions. They were situated over a space bounded anteriorly by the posterior border of the tensor vaginæ femoris muscle, posteriorly by the anal furrow, below by a line drawn horizontally through the trochanter minor of the femur and above by the middle curved line on the ilium. The lesions occupying this space varied in size from a pin-head to a ten-cent piece, were circular in shape, entirely separate and distinct one from the other, the skin between them being normal as far as objective examination could decide. There was not any grouping of the lesions. They were slightly depressed below the level of the skin and consisted of a black dry eschar surrounded by a narrow red line of demarcation. They were extremely adherent and could not be separated en masse. When one was finally removed, it was seen that the deeper portions were softer and slightly moist. The destruction of tissue in the larger lesions extended to the subcutaneous connective tissue, but was more superficial under the smaller ones. It was also found that complete anæsthesia existed around the larger lesions for a variable distance, but over the acetabula this condition extended over an area of 2 x 3 inches. Pressure over the spinous processes of the last lumbar vertebra and over the upper portion of the sacrum produced considerable pain.

The treatment ordered was counter irritation over the spinal cord in the regions just mentioned and antiseptics. The eschars separated slowly and in about three weeks cicatrization had occurred. The anæsthesia had disappeared on the 20th of December. The patients general condition during the whole time had been in every way satisfactory and since that time he has enjoyed good health.

This curious case, which from all the characteristics of the lesions was one of multiple gangrene of the skin, was referred to

by me at a meeting of the New York Dermatological Society in the course of a discussion on zoster.<sup>1</sup> I stated at the time that I was in doubt where to place it, but was inclined to consider it allied to *Herpes zoster gangrænosus*. Since then, however, consideration of the entire history leads me to range it in that class of cases, in which symmetrical gangrene has been observed to follow upon severe protracted and excessive exertion, several of which have been reported by Hochenegg in his brochure on "Symmetrical Gangrene." The neurotic nature of this case seems to be quite evident, owing to the distribution of the lesions over the gluteal nerves, the anæsthesia so markedly present, and the tenderness on pressure over the vertebræ. I would regard the process which produced the gangrenous spots as a trophoneurotic one, and the cause of the disturbance producing it, the unusual exertion to which the patient was subjected before December 7th.

The differentiation of this form of gangrene of the skin from those which have other and entirely different inducing causes is of some value for treatment. Gangrene occurs in zoster and zoster oftentimes is traumatic in origin. It is also a trophoneurotic affection, still it is very rarely symmetrical and is characterized by the outbreak of grouped vesicles on a reddened base. The gangrene is secondary to these, though it may occur very quickly after their appearance.

The diagnosis of gangrene depending upon Bright's disease or diabetes is facilitated greatly by the general systemic symptoms belonging to each of these diseases, since it occurs in the later stages, usually a few months before death.

The idiopathic gangrene due to insufficient nutrition supplied to a part or caused by thrombosis or embolism, or some other circulatory disturbance, does not come into consideration here, neither does the gangrene following after severe febrile affections, nor senile gangrene, due to the atheromatous changes in the afferent arteries, nor does the gangrene occurring as the result of syphilitic endarteritis, etc. All of these forms are recognized from the general symptoms attending each, which are entirely distinct from those due to a trophoneurotic disturbance.

One form of symmetrical gangrene, however, occurs without any appreciable cause—Raynaud's disease. This can be recognized by its chronicity, its localization primarily on the phalanges of the fingers and toes, the intense pain accompanying

<sup>1</sup> *Journal Cutaneous and Venereal Diseases*, August, 1887.

its development, the severe vasomotor disturbances preceding it and shown by local ischæmia, local cyanosis and local redness, each one of which may appear by itself or one form follow successively upon another.

The treatment of acute multiple gangrene, due to the causes which produced it in the case reported here, may be said to come under the head of antisepsis. The various antiseptic substances may be used during the time that the eschars are separating, or what is better, these latter should be removed mechanically as soon as the line of demarcation has developed and the wound should be dressed properly. Rest should be enjoined, but any internal medication is useless, except such as may be indicated by some disturbance of the physiological functions of the body.

## II.—RELAPSING DOUBLE ZOSTER.

Carl S —, a German, æt 39, a porter by occupation, presented himself at my clinic at the Demilt dispensary on April 29, 1887. He stated that he had acquired syphilis five years previously, while still in Germany, and had been treated for it. Three weeks before coming to the dispensary, he had had an attack of intermittent fever for which he took some quinia. About a week later, he observed an eruption, which appeared in patches on the left side of neck and extended from the median line posteriorly to the border of the sternomastoid. The eruption was unaccompanied by either pain or itching. Similiar lesions appeared on the right side of neck about eight or nine days later.

When the eruption was examined, it was seen that on the left side of the neck, the patches were distinctly visible, but only crusts remained on them and a few abortive lesions were present here and there, but on the right side the groups of vesicles were marked. The largest one was situated near the median line posteriorly, and upon it were some twenty characteristic herpetic vesicles, both discrete and confluent in places. The base upon which they were situated was bright red and slightly elevated. The eruption was situated over a portion of the distribution of the posterior branches of the last four cervical nerves and of the cervical plexus.

Under tonics and local treatment the eruption disappeared, but the patient complained at the time of his second visit, that he was suffering from most acute muscular pains throughout the entire body. He was given salicylic acid and kalium iodatum in ten grain doses, but returned two days later and stated that after taking one dose, he had had a feeling of suffocation and the tongue became considerably swollen. These symptoms, he informed me, had always immediately followed

the administration of the iodide of potash, when he was under treatment for syphilis in Europe. In consequence their appearance could be ascribed to this drug and not to the salicylic acid. The general pains for which the medicine had been given had, however, disappeared and the patient was not seen again until June 16th of the same year. He then returned to the dispensary and stated that on June 11th and 12th he had had attacks of chills and fever and had taken quinine, how much he could not say. On the 13th, the eruption began on the left side of the neck in the same situation as in April, and on the 14th, the patches appeared on the right side. He suffered on this day from very severe occipital headache. When examined, a large patch on left side was seen and upon it were grouped vesicles, more or less angular in shape and filled with a straw-colored liquid. There were also on this side two smaller patches, on which, however, the lesions had not yet become vesicular. On the right side of the neck, there were similar patches. Their bases were dark red and it was evident that hemorrhagic effusion into the tissue had occurred. The patient complained of a sensation of formication in the patches. He was given a tonic of iron and nux vomica and the eruption, having disappeared under local treatment, he was again lost sight of until August 18th. On this date he returned, on account of an eruption consisting of a few groups of vesicles, perfectly herpetic in character, which were situated on the right side of the dorsum of the penis and the corona glandis. He also stated that he had had in July another attack on both sides of the neck, which was identical with the preceding ones for which he had consulted me. The eruption on the penis was healed in a few days and since that time, the patient has not been seen.

The first attack from which this patient suffered was very briefly described by me at the 173d meeting of the New York Dermatological Society, but the interest in it was greatly increased on observing the subsequent eruptions. Double zoster of itself is extremely rare, and the occurrence of relapses in the disease still more so; but the combination of the two together is, as far as I have been able to discover, an unrecorded fact. In consequence, this case deserves to be considered as a unique one in every way. The outbreak of the lesions occurring after taking the quinia might suggest a connection between the two, still I should look upon any such conclusion as an extremely daring one, which it would be difficult to prove. The diagnosis of zoster is one which offers no difficulty. It is to be based on the unilateral eruption—the rule—composed of groups of vesicles situated on a reddened base and following the distribution of one or more nerves. It is sometimes preceded by fever

and often by severe pain in the affected nerve. This often disappears with the outbreak of the vesicles, but may also persist for some time after and even for life. The treatment of zoster must be directed towards keeping the vesicles from rupturing and insuring their drying up. For this purpose starch powder, or some other protective applications may be used. It is best to combine them with some antiseptic to prevent secondary infection. For the neuralgic pains so often present with zoster, I have used for some years the Paquelin cauterly at a red heat. With this, the skin over the origin of the nerves is superficially cauterized, but not so deeply as to produce scarring. This method of treatment—one first suggested by Dr. Halstead at Roosevelt Hospital, I believe—has never yet in my experience failed to relieve or entirely remove the pain.

### III.—BULLOUS ERUPTION PRODUCED BY QUINIA.

Catherine D——, æt 43, a native of Ireland, came to my clinic at the Demilt Dispensary on January 14, 1888. She states that she has suffered from malarial fever off and on for nineteen years, her health in the intervals between the attacks being, however, always good. She had always taken quinia without its producing any ill effects, but in May, 1887, when suffering from periodic attacks of dizziness, accompanied by slight fever, she was given five grains of quinia and for the first time an eruption ensued, which at the time was similiar to the present one. The same symptoms recurring in November, 1887, she again took five grains of quinia and its administration was followed within an hour by the first evidences of the outbreak. The symptoms preceding the present attack were dizziness, slight fever and nausea from the 9th to the 13th of January, on which date, she took two Pill. Cathart. Co. After they had acted, she swallowed a capsule containing grains V of quinia at 2 P. M. At 4 P. M., a burning and itching sensation began to be felt in the hands, the lips, the mouth and the eyes. These symptoms kept increasing in severity and in about one hour, lesions began on the backs of the hands. During the night, the eruption increased and appeared on the wrists, the feet, the lips, tongue and roof of mouth. The surfaces implicated became very sore and painful. When seen by me, it was noticed that there was an erythematous lesion over the second phalangeal joint of each index finger. It was as large as a penny, elevated, resistant, very painful and of that dark purplish color indicative of hemorrhage. On the back of the left hand, there were several small bullæ and one very large bullous lesion 2 x 1 inches. This latter was more or less oval in shape and presented peculiar characteristics. The central portion had flattened down was

of a dark purplish hue and was surrounded by an elevated broad bullous border. The walls of these bullæ were quite thick but there was only a moderate amount of fluid contained in them. On the palm of the left hand, there were three dark red, circular and painful erythematous lesions as large as a penny, and on the arm to midway, there were also a few similar spots and a number of deep-seated bullæ of various sizes.

On the right hand, there were also several bullæ, but none with the sunken-in center and peripheral wall as on the left. On the right arm, the eruption was marked. Two of the bullæ here were an inch in diameter and there were five or six others of various sizes. The right half of the lower lip was also occupied by a bulla, and on the tongue and the mucous membrane covering hard palate, there were distinct circular losses of epithelium where the patient stated the "blisters" had been. On the feet, there were only a few lesions; on the body, none. The patient was quite deaf.

The treatment given was a placebo and the eruption retrogressed rapidly, but on the 16th of January, new bullæ appeared on the lips and hard palate. They subsided quickly, no new ones appeared and on January 24th, there were only slightly reddened spots where the lesions had been.

The fact that the patient had suffered from similar attacks twice previously after taking quinia and at no other time, would naturally establish the connection of the lesions with the drug. The eruptions, which are due to quinia manifest themselves under various forms, but perhaps the one most commonly met with is the urticarial. The rarest is the bullous, of which only very few cases are recorded (five or six, I think). The one reported here would belong to this division of the quinia exanthemata and it shows also the peculiarity mentioned by Dr. Morrow, in his book on "Drug Eruptions,"<sup>1</sup> that the idiosyncrasy can be an acquired one and not have always been present. The diagnosis of these eruptions must naturally depend upon the knowledge that quinia has been taken, for in the lesions themselves there is nothing to designate that fact. Full descriptions of these drug eruptions are to be found in the book referred to above, which should be consulted by those interested in the subject.

#### IV.—LICHEN RUBER PLANUS.

Mary B—, æt 21, American, presented herself for treatment at my clinic at the Demilt Dispensary. Her general health is perfect, she is stout and well made and her functions are in normal condition. She can give no history precedent to the appearance of the lesions, which throws any light upon their

<sup>1</sup> Morrow. *Drug Eruptions*, 1887.

possible causation, not having been ill in any way. The eruption began one year ago on the flexor surfaces of the forearms as red, itchy, dry lesions of various sizes. They have continued appearing and, when examined by me, were found on those surfaces and quite numerous around both olecranon. There were likewise quite a number on the arms, shoulders, around the lips and here and there on the trunk. A few were also seen on the palms of the hands, but none on the lower extremities. The disease was present in addition on one surface, greatly increasing the interest of the case. On the mucous membrane of the lower lip there was an irregularly circular lesion of the size of a penny, the periphery of which was formed by six small elevated papules covered with whitish epithelium. The central portion had sunken in, being on a level with the mucous membrane of the rest of the lip, and was covered with ragged epithelium. The papules were sharply defined and there was no induration of the base of the lesion, which had been first noticed one month before. Subjectively, she complained of a sensation of itching. On the mucous membrane of the left cheek, there was again a single papule and on the tongue, two well-defined, slightly elevated, flattened lesions, covered with only little epithelium and of pink waxy color.

The eruption on the body and extremities consisted of discrete lesions of various sizes, but mostly as large as a pea. They were very itchy and had been for the most part scratched so severely, that pieces had been dug out of them. Yet, by careful observation, lesions having a pale, pink, waxy appearance, more or less angular in shape with a flat top and a slight concavity in their centres were found, and likewise large ones, with rounded tops—lichen obtusus. Here and there were also seen brownish discolorations where lesions had disappeared.

The interest of this case is greatly enhanced by the presence of the lesions on the mucous surface and the possibility of an error in diagnosis being made under such circumstances is materially increased. Lichen planus does occur on these surfaces and when it is found there, every symptom of the entire affection should be carefully considered before concluding what its nature is. The disease would be most apt to be confounded with the papular syphilide. The lesions of this latter on the skin are sharply defined, of a dark coppery-red, infiltrated, of various sizes, and as a rule involution takes place in them in six weeks to two months after their appearance, if they have not been treated. A few rare cases have been seen, as mentioned by Bassereau, in which the eruption, by means of constantly recurring outbreaks, has lasted for one or two years, but these are so exceptional that they may be left out of the question.



With the papular syphilide, as it occurs early in the disease, there will be found the general systemic symptoms of syphilis—the enlarged glands, nocturnal pains, etc. When the papular syphilide occurs late in the disease, it consists of grouped lesions, which usually undergo the serpiginous or creeping course of the syphilides of that stage. The lesions of lichen planus, on the other hand, run a chronic course, accompanied by quite severe subjective sensations of itching and without any general systemic disturbance. The lesions are angular in shape, with flat tops, pale pink in color and waxy in appearance. They show in many instances a small concavity or depression in their centres. The lichen obtusus papules correspond in general symptoms to these, except that they are larger, rounded on top and do not show any depression. They are found, to a greater or lesser extent, mixed with the ordinary planus lesions.

The papular syphilide of the mucous surfaces—the well-known mucous patch, which, when the syphilide is general over the body is situated around the anus, genitals, etc., and present symptoms never seen in lichen planus, is recognized by its sharp circumscription, the reddened or opalescent epithelium with which it is covered, the superficial or deep ulceration developing after it has been for a short time present, its usual co-existence with a papular syphilide on the body, the general systemic symptoms which accompany the disease and its great tendency to recurrence. The lichen planus lesions on the mucous membrane of the mouth occur under the form of elevated papules, for the most part flattened on top, of a whitish color and they are coexistent with planus lesions on the integument of the body. They run a chronic course and undergo sometimes atrophy in the centre, but not ulceration, and are usually itchy. The lesion on the lower lip in the case reported here might have suggested an initial lesion, but this latter was readily excluded when it was considered, that though present for one month no glandular enlargement had yet occurred. Besides, the absence of erosion of the surface, of induration of its base and the general characteristics of the lesion—its border composed of several lesions surrounding a depressed, slightly atrophied centre—ought to be sufficient to have prevented any error in diagnosis having been made.

V.—*LICHEN RUBER ACUMINATUS.*

Miss A—, æt 25, American, came to my office on March 5,

1887, to consult me in regard to an eruption, the first symptoms of which she had noticed in the beginning of December, 1886. It had then appeared around the waist under the form of small papules, which were red and very itchy and which became slightly squamous. From the point of inception, the eruption gradually spread, until, when I examined her, it was situated over the abdomen, thighs, back, chest and neck especially, but also to a lesser extent on the extremities. The face was free. The lesions were arranged in diffuse patches, which were, for the most part, composed of small, conical papules, the size of a pin-head, which had developed around the hair follicle. Upon them small scales of epidermis were seen. They were red, but some were brownish in color. Among these were also seen quite a number of larger size, angular in shape, having a pink, waxy appearance, and a slight concavity in the centre—lichen planus lesions. The patient says that the small, conical papules were never smaller, nor did they show any tendency to enlarge. The only change which she could notice was the continual appearance of new ones and their closer aggregation on the patches.

The itching was intense and paroxysmal in character. The patient was exceedingly nervous and irritable. She was not very strong, had lost flesh and was rather anæmic, but her general functions were normal.

In this case of lichen ruber, both forms of the disease were coexistent—the planus and the acuminate form—and I would take occasion here to state my entire belief in and my adherence to those, who hold the opinion that lichen planus and lichen acuminatus belong to the same disease—lichen ruber. That in doing this I differ from the consensus of opinion among the dermatologists of New York, with the exception of one, can be seen by reference to the transactions of the New York Dermatological Society (JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, August, 1888); still the cases which I have seen lead me to hold that view of the disease. Besides, the experience of the best dermatologists of the continent of Europe and the literature of lichen ruber alike support the opinion of the relationship existing between them, and the weight of authority of these two seems to me to effectually dispose of the matter.

The acuminate form of lichen ruber is rarely met with and requires considerable care in making the diagnosis. The primary lesions are small and conical and develop around the hair-follicle, do not increase in size and always remain papules—that is, do not become vesicles or pustules or undergo any further change. The lesions become confluent through the cropping up

of new papules between the primary ones and small scales of epidermis are present. The affection is a chronic one, excessively itchy, very rebellious to treatment and death often results from marasmus. The symptoms, which have just been given, sufficiently characterize lichen acuminatus, but it may be well to mention the principal points which will differentiate some other affections from it.

Psoriasis punctata can be on its first appearance mistaken for lichen acuminatus or vice versa. But it will be observed that the small lesions of psoriasis enlarge quite rapidly and very soon present characteristic symptoms in regard to profuse disquamation, etc., conditions never seen in the lichen.

In eczema papulosum, the diagnosis is simplified by the coexistence of vesicles or small pustules or crusts. An eczema always shows more or less evidences of exudation and on some portion of the surface affected, such will be found. In lichen acuminatus, however, as already mentioned, the lesions appear as papules and remain papules.

When the lichen acuminatus has become diffuse or universal the differential diagnosis between it and universal psoriasis is exceedingly difficult, unless some primary lesion is found and distinguishable through the involution of some portion of the disease. This occurs more frequently in psoriasis, in which also the palms and soles are usually unaffected.

From universal chronic eczema, the lichen is more easily separated, inasmuch as in the former weeping or other symptoms of exudation are found here and there.

In conclusion, allow me to say a few words in regard to the treatment of lichen ruber. Arsenic has always been recommended and found of great value. It is best administered in the form of the Asiatic pill, but is practically useless unless given in rapidly increasing doses, until the patient's point of toleration is reached. Then diminishing the daily number of pills by one or two, the arsenic is to be kept up until the disease has disappeared. Alkaline treatment, etc., etc., have also been time and time again recommended, but they stand for the most part in the light of placebos. Very different from these, however, and distinguished from them by the rapidity with which it acts in lichen ruber, is the external treatment which we owe to Unna. It consists in the use of hydrargyrum bichloridum and acid carbolicum combined with the ungt. diachylon of Hebra. The percentage of bichloride varies from grs. ii—grs. x, xii and even xv or more to the ounce of the ointment. It is best to be-

gin with a small percentage and increase gradually until the effect is noticed. Some cases react to a very small amount, while others require a much larger quantity, facts only recognizable by observation of the individual case. The carbolic acid is of the strength of 2-5 per cent. It gives me much pleasure to be able to attest to the value of this application and to corroborate on my part the success, which my friend Dr. Unna has obtained from its use. I have applied this ointment locally and to the exclusion of all other treatment, on many cases of lichen ruber and have not yet seen it fail to remove the disease rapidly and effectually. There does not seem to be any reason to fear the amount of the bichloride used, especially if the patient is carefully watched. In one case which was under my care and in which the disease was over the entire body, in the form of discrete planus lesions, no mercurial symptoms developed, notwithstanding that the ointment was applied twice daily over the entire surface for a period of six weeks, when the disease having disappeared, the treatment was stopped. Individual idiosyncrasies may, however, be met with, and for that reason it is best to begin with small percentages.

Sometimes large planus lesions are met with, especially on the lower extremities, which show no activity, but are dense, infiltrated and excessively itchy. Such lesions have been materially improved when touched with pure carbolic acid every day and Unna's ointment used during the rest of the day. Resorcin has also given me good results and in a case of lichen palnus of some eight years' standing, lately under my care, it proved of decided benefit. The lesions in this case were as large as a penny, hard and dense, covered with a considerable amount of scales and most intensely itchy. I applied the Resorcin (seven per cent.) combined with ungt. diachylon and added to it two per cent. of acidum salicylicum. It was used on the lesions during the day and was replaced by Unna's ointment at night.

R Hydrarg. bichlor.....grs. xv.  
 Acid carbolic.....grs. 20.  
 Ungt. diachyli (Hebra).....3 i.

The lesions on the mucous surfaces, I have always treated locally, by touching them every two or three days with pure carbolic acid and the results have always been eminently satisfactory. It only remains for me to add that the same treatment is applicable, whether the lesions present be of the planus, of the obtusus, or of the acuminatus form of lichen ruber.

## VI.—PAPILLOMA ANI, PERENNI ET PENIS, POST ECZEMA CHRONICUM.

A. L.—, a Norwegian, æt 31, came to my office on April 10, 1888. He stated that he had suffered for a long time from hemorrhoids, but that two years ago, they had become aggravated and there was a continual discharge from the rectum. This discharge kept the parts around the anus continually moist and in a condition of irritation. They became itchy and under the combined action of scratching and of the discharge an eczema developed. He consulted a "physician" who advertises in the daily newspapers and was treated entirely internally, no applications to the eczema being made. About a year after the eruption had lasted, he noticed that the skin immediately around the anus had become warty. Still the internal treatment was kept up and no attention given to the changes taking place at the seat of the disease. The papillary proliferation consequently progressed rapidly and when I examined the patient, the growth occupied the entire anal furrow, from the coccyx posteriorly to the perineum anteriorly, covered this latter and extended over one-third of the under surface of the penis. The general characteristics of the growth were those of a papilloma. There was not any ulceration visible, but when the growth was removed, it was noticed that the portion immediately around the anus was superficially eroded.

Under the circumstances, any treatment except an operative one was entirely out of the question. I therefore referred the patient to Dr. Frank Hartley who removed the growth en masse.

Eczematous eruptions around the anus occur very frequently and result from many causes, such as hemorrhoids, discharges from the rectum, etc., one of the most common, however, being a precedent pruritus ani. The eczema having been established, it is not infrequently seen that the affected surface of the skin undergoes a papillomatous degeneration. This papillary proliferation on an eczematous base is not limited to the region of the anus, where two cutaneous surfaces lie in contact, but it also occurs on old chronic patches on the free surface, which have been subjected to long-continued irritation, or to defective circulation, as on the lower extremities. Where the eczema is situated on two surfaces in contact with each other, however, the skin is macerated and kept in a condition of intense irritation by the retention between them and the decomposition of the secretions and the exudation from the diseased skin. Further factors of no small value are the movements of the surfaces upon each other and the scratching caused by the severe itching.

Under the influence of all these factors, the skin also becomes thickened and infiltrated, the circulation supplying the cutis more or less disturbed and the conditions favorable to the papillomatous changes are present.

It is not, however, always easy to decide what the nature of the basic disease is, upon which the papilloma has developed. It may have been eczema, or lupus, or tuberculosis, or syphilis, or the growth may be a primary epitheliomatous one. Still, an accurate history of the changes preceding the papillomatous growth aids greatly, but a much safer course, in case of doubt, is the use of the microscope. It should also be borne in mind that papillomata frequently undergo epitheliomatous and sarcomatous degeneration, even though they may have developed upon a perfectly benign base.

The treatment of eczema ani is a voluminous subject, and would require too much space to be considered here. Still, I would mention several points which may come under the head of prophylactic treatment, as far as the development of papillomata in that situation is concerned, and which are also of importance in the treatment of the eczema. The cause of the eruption should be sought for and treated directly, for with its removal the cure of the eczema is an easy matter. The diseased surface should be treated by *local applications*, internal treatment is called for only when indicated and has no direct action upon the disease; the two portions of skin which are in contact must be kept completely separated from each other by the interposition of absorbent cotton or some such material.

When the papillomata have developed around the anus they should be removed with the knife, or, if small, with scissors, or the cautery or the sharp spoon.

#### VII.—EARLY RUPIA IN SYPHILIS.

B. W—, æt 20, American, an artist's model, came under my treatment July 20, 1887. She is gracefully built, and has a perfect auburn complexion. Was unmarried, but lived with a man whom I found had traces of old syphilis and one group of cutaneous gummata on leg. How long she had lived with him neither party would say. She stated that her health had always been perfectly good up to the commencement of this attack. She had been pregnant once, and in September, 1886, had been delivered of a full-term, but still-born child. The labor had been normal and she had felt in every way well afterwards. In the beginning of March, 1887, however, her throat began to hurt her when she swallowed anything and the left tonsil was found to be enlarged and ulcerated. The symptoms resisted the

treatment applied; the glands on that side of the neck began enlarging in about ten days, to be followed by those on the other side. In the middle of April, she first noticed an eruption on the face and then on the body, which consisted of reddish spots of various sizes—macules? These disappeared in a short time and at the end of May, the present eruption began to make its appearance. The lesions developed on the face first and then gradually cropped out over the entire body. The patient was all this time under treatment, but since the effect of it was nil, it is probable that the diagnosis of syphilis had not been made. At any rate, she said that she was told she had diphtheria and the lesions were sequelæ of that disease.

The patient was in such a pitiable condition, emaciated, anæmic and weak, when seen by me, that she was immediately admitted into the Skin and Cancer Hospital (Dr. Bulkley's service). On examination, a number of recent cicatrices were found present on the face and on the ears, and in the eyebrows, there were a few ulcers, which were circular, with sharp, punched out edges and dirty-greyish base. There were not many lesions on the body, but they were numerous on the arms, buttocks and shoulders. The legs, however, from Poupart's ligament to the feet, were thickly studded with lesions—100, by actual count. Many of these were ulcers, the remainder were thick, heaped-up, blackish and greenish-black crusts, which resembled oyster shells. When any of these were removed, it was found that they covered an ulcer, the base of which was filled up with necrotic tissue and thin, ichorous pus. The lesions on the arms and rest of the body were similar to those on the legs and there were also here and there a few pigmented cicatrices. The size of the ulcers varied from a dime to a silver dollar. The patient was given sol. sat. kalium iodatum. Beginning with qtt. v. three times daily, it was increased until xv. was reached; this was continued for a week and then the amount was rapidly pushed up to 105 drops daily. At the same time gtt. 20 of the tinct. ferri pomati (Ger. Ph.) was administered, also milk punches, good nourishment, etc. The crusts covering the ulcers were removed and these were, wherever situated, dressed twice daily with

R. Ungt. Hydrarg. .... 3 i.  
Ungt. Calamini et Zinci oxidi ..... 3 vii.

The patient responded immediately to the treatment, got stronger, increased in weight, the ulcers cicatrized and she was discharged from the hospital on August 17, 1887. She has, however, remained under general treatment since then and no relapse or syphilitic symptoms of any kind have reappeared.

It seemed to me from the history given by the patient of the disease as it developed, antecedent to the date of her first visit

to me, that the probable and presumable point of infection was the tonsillar ulcer present in March, 1887. In favor of that are the glandular enlargements beginning shortly after, the general eruption occurring in April, the entire absence of any symptoms prior to these. It might be that she acquired syphilis at the time she was pregnant, but the rule in such cases is for a miscarriage to follow and not a full-term still-born child. Altogether, I would regard the case as one of early rupia.

The following additional case, however, is not open to any possible objection :

J. C—, æt 16, was first seen by me at the end of September, 1884. He had been on the training ship St. Mary, which stopped at Gibraltar in the last week of July of the same year. He had gone on shore and had had connection with a prostitute and had not had any opportunity to repeat the act since then. An initial lesion developed on the penis at the end of August, and when he consulted me he had a severe general papular eruption on the body, mucous patches in the mouth, and the usual symptoms attending the outbreak of an early syphilide. He was given appropriate treatment, but was not seen again until November 17, 1884. He then presented a general rupia eruption, which was most severe on lower extremities, but was also extensive over the rest of the body.

In this case we have the unusual fact of a general rupia developing three and a half months after the infecting coition, and in the other case about four months after the initial lesion—regarding the tonsillar ulcer as this latter.

The occurrence of rupia as a general eruption is not common, but it is most usually seen as a few lesions scattered here and there or only one single crust may be present. This form of pustular syphilide, moreover, belongs essentially to the late stages of the disease, but when it does occur early after infection, it is usually in the generalized way shown by these two cases. The lesions themselves are so characteristic, that it is scarcely necessary to enter into the differential diagnosis between them and those of other diseases possibly resembling them, but I would add a few words in regard to the treatment.

Syphilitic treatment is of course called for, but I have found that the most rapid results were obtained when the iodide of potash was administered uncombined with mercury, and this latter was applied locally. I always use in rupia and also in all syphilitic ulcerations the ungt. hydrargyrum diluted with ungt. zincum oxidum in the proportion of 1-8 or 1-4 as a local dressing, to be applied fresh twice daily to each ulcer. Where there



are a great number of these latter, the patient should be carefully watched for the slightest evidence of mercurialism either of the mouth or the bowels, and if this is done little risk will be run. Tonics and nourishment should also be freely administered, for it should be remembered that a pustular syphilide always means a lowered condition of the general system. The results, which I have obtained from this manner of treatment, have always been good and rapid. The cases can certainly be treated by internal medication alone if desired and a result finally obtained, but it will be much slower—certainly a method more lucrative to the physician in charge, but still scarcely as satisfactory to his professional pride as though the cure had been more rapid.

No. 45 EAST THIRTIETH STREET.

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REPORT OF AN UNUSUAL CASE OF NÆVUS, AND A CASE OF  
FAVUS OF THE NON-HAIRY SKIN.

BY

HENRY J. REYNOLDS, M.D.

Professor of Dermatology, College of Physicians and Surgeons, Chicago, etc.

(Read at Thirty-ninth Meeting of the American Medical Association.)

**J.** E. H—, æt 10, native of Minnesota, American parents, father healthy, mother died of inflammation a few days after the birth of the child, who is the subject of this report. The child has had ever since birth a thick, fleshy, prominent, darkish, purplish colored growth, extending from a little below the left knee up to above the crest of the ilium. The growth encircles in the lower part the entire leg, with the exception of a narrow strip on the inside. Viewed anteriorly, as it extends from below up, it recedes slightly to the left, so that the inner margin of the upper part reaches about the anterior superior spinous process of the ilium. Posteriorly, above the buttocks, it extends slightly beyond the median line to the right (as may be seen in the accompanying cuts). When first seen, some three months ago, the growth was traversed over almost its entire surface by numerous deep furrows. He has always been troubled with a profuse serous sort of discharge, with a very offensive odor, so much so in fact that he was deemed unfit to be in school with other children. Owing to the maceration and irritation of the parts, caused by the discharge or moisture, the growth has always been in places attended with more or less irritability or soreness. Portions of the surface of the growth are covered by a hard, scaly sort of substance, resembling somewhat an aggravated ichthyosis; long delicate hairs were dis-

tributed more or less scantily throughout the entire affected region. Another interesting feature in this case is the fact that the affected leg is about two inches longer than the other one; otherwise the child has always been healthy.

He had been treated more or less by various physicians, but never received much benefit. I ordered the part washed once a day with soap and warm water carefully, and impalpable boric acid applied three times a day. I have not seen the patient since; but the following extract from a letter received from his

father a short time ago explains itself. He says: "In regard to my son, whom I brought before you on February 8th, I can say that your treatment is the best remedy I have been able to find yet. The offensive odor and discharge have almost stopped, and the thickening is growing thinner in places, and the limb is in better condition than it has been since he was born, or since I have been paying close attention to it."

The above case is interesting principally on account of its very unusual character and the striking deformity which it pro-

duces. I am firmly impressed, however, that were the patient and friends able and determined to persist in thorough treatment in the way of local applications—soap frictions, compression, galvanic punctures, etc.—the disease or deformity could in time be approximately eradicated.

#### FAVUS OF THE FOREARM.

The following case is deemed interesting chiefly on account of the very unusual location of the parasitic growth.

Occurring upon the scalp, tinea favosa is a somewhat rare disease, and to extend from the scalp to the non-hairy skin of the same individual is a still more rare occurrence; but to develop exclusively on the non-hairy skin is a circumstance not very often met with.

April 7, 1888.—M. L——, æt 7, of Jewish parents, and otherwise healthy, referred to me for treatment by Dr. M. E. Lane, of this city. Examination revealed a roundish patch of erup-

tion about three-quarters of an inch in diameter on the flexor surface of the forearm, about the region of the junction of the middle and lower thirds. Exactly in the centre of the patch was a bright sulphur-yellow-colored, umbilicated crust one-quarter of an inch in diameter, with a crack across its centre, showing its brittle character. By careful examination, three or four beautifully defined smaller cups, about the size of the head of a pin, could be observed here and there over the patch, otherwise the remainder of the patch was to all appearances identically that of ordinary ringworm, with a reddish, slightly elevated abrupt margin and a centre tending to become paler and covered slightly with fine scales. Examination with the micro-

scope showed the crust to be composed entirely of favus spores; scales from the reddish margin contained principally mycelia with a few smaller spores, which, as far as I was capable to judge, were identical with those found in ring-worm.

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#### ELECTROLYSIS IN URETHRAL STRICTURE.

BY

C. A. BRYCE, M. D.

HAVING read with much interest the careful *resumé* of Dr. F. T. Brown on the above subject, which appeared in the July and August numbers of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, I beg leave to briefly present a few suggestions, explanations, and practical examples of the behavior of the galvanic current as applied by myself in cases of urethral stricture. I am led to offer this paper for publication for the sake of the method itself, and certainly not for any reply to any adverse criticisms on the practice as I pursue it; for I am fully satisfied with the results, and my patients are relieved and remain in perfect health.

Much *theory* will be found along with little fact in the great bulk of medical and surgical literature. The subject of electrolysis in stricture has been handled and discussed at great length from a theoretical standpoint, and has, from time to time, received both encouragement and abuse by reason of deductions, *pro* or *con*, from these theoretical premises. It does seem perfectly reasonable to suppose that when a patient has been afflicted for years with a painful and ever-present malady, and when a certain remedy or surgical proceeding is resorted to and recovery—or *absence of all former inconvenience and suffering* follows such remedy or procedure—that we should ascribe such recovery to the effect of the means used. We take this, therefore, as the basis of claim made by ourselves—and others, we hope, equally as conscientious, to having effected certain cures of stricture by electrolysis. We do not feel called upon to go into details and explain why Dr. Brown has not been successful with electrolysis in stricture; we cannot do so, because we know nothing of the circumstances attending all of his manipulations in the treatment. We can only speak from personal knowledge, and hence we have no criticism to make on Dr. Brown's cases.

We regret to see the intemperate expressions in which the

doctor indulges when he accuses the reporters of more successful cases than his own, of a want of "keen appreciation of truth." Of course, if our veracity is to be called in question, all of our labor will be in vain; for our efforts are to satisfy our readers, whether they are in accordance with our theory or not! It is perfectly easy for us to furnish the same old story of the chemical effect of the galvanic current on compound substances, and say that this is the *principle* upon which we decompose a stricture.

For the sake of brevity, and to prevent useless discussion, we will simply ignore the entire theory or *modus operandi* of the current, and discuss the results or sequences of its use. It will be conceded that fifteen grains of calomel with as much soda given to the average patient will produce some decided purgation within from six to twelve hours, as a general rule, and we hardly think any one will deny that such effect could be credited to anything but the agents mentioned. We do not know that the *exact* chemical or mechanical action of calomel under such circumstances can be scientifically explained either!

We will not give the experience of *others* in the several methods of treating stricture but will confine ourself to the experience we have derived from quite an extensive practice in this class of troubles. We therefore distinctly put ourself upon record as follows:

We have not been able, by any method, except electrolysis, to give a patient a full urethral calibre and have him go as long as *twelve months* without the use of instruments, or without such diminution of his stream as to clearly show the necessity of continued treatment to prevent serious trouble. Neither dilatations, divulsion nor urethrotomy will *remove* the morbid tissues constituting stricture and as long as they are present re-contraction and spasmodic troubles will occur. *This has been our invariable experience.* Now even admitting that in electrolysis we get the benefit of dilatation mechanically, and thus give credit to the current which should be ascribed to the mechanical stretching of the tissues (which we do not for a moment admit), we would ask: Why it is that in the one instance no cure follows, and in the other a cure will usually follow? We beg leave to introduce the following case, and the name of the physician bringing him to us, who had exhausted "the usual means" without benefit.

Mr. J. M——, æt 63, was brought to me by Dr. J. G. Trevilian, of this city, on April 3, 1883. Mr. M. had been suffering

with stricture for several years. His condition when he presented himself for treatment was as follows: Great pain and difficulty in urinating, with frequent calls to empty the bladder. He would have to arise from his bed many times every night to strain a small quantity of urine from the bladder, and during the day motion would aggravate the trouble. In short, he was in constant pain and irritation during all of his time when awake, and when asleep he would be awakened to attend to the calls to urinate. Examination revealed a dense and long stricture of the entire membranous urethra, and two filiform guides were all that could be gotten through the strictures. He was accustomed to *walk* from Manchester to my office, because the jolting street cars provoked his bladder to such an extent that he could not remain on them. To be brief, I will state that he was gradually treated by electrolysis until his urethra was restored to 21 of the French scale (its normal calibre), and he was discharged cured on June 26, 1883, and has remained entirely well, requiring no other treatment of any kind, up to the present time, June 1, 1888.

Our conclusions are:

1st. This was a case of stricture.

2d. Other methods had failed.

3d. Five years of absolute health without a single resort to any drug or instrument during that period would justify us in calling this a *cure*.

4th. We believe we cured this man's strictures by electrolysis. In the language of the little boy who asked "ef hourse doan spell hoss what do it spell den?" we would say, if electrolysis did not cure this case, to what agency can we ascribe the lasting good results following the treatment?

We present this case as being of special importance:

Mr. H. M—, merchant, æt 28, has had stricture of the meatus and gleet for two years. This case was very slow in consequence of the very great contraction and subacute inflammation setting in from the slightest manipulation. I finally disregarded the inflammatory condition, and with a flexible conical electrode bougie 24 French, and 18 cells of a Stammers' battery, worked through, and thoroughly broke down the stricture. Quite a high grade of inflammation set up, which soon subsided leaving the meatus free from all contraction and easily admitting a No. 21, French scale. He has remained entirely well up to this time (four years). This case illustrates the fact that electrolysis will substitute internal incision, even at the meatus.

We see this man frequently and know that he has remained absolutely well, not requiring any attention of any kind for his

former trouble. We consider the period of four years long enough to claim a *cure in this case*.

This last case will serve to show Dr. Brown our reasons for asserting that after an absorption has been started by the current, nature helps on in the good work.

Rev. W. H. L.—, stricture of five years' standing. Had total retention while residing in Philadelphia, which was followed by another attack in about one month, when he came to consult me. I could get nothing into the urethra but a filiform guide, and in this way relieved the retention. Owing to pressing engagements, this gentleman could not spare the time to undergo treatment to its full extent. But I worked into the bladder with a No. 14 French electrode, and at this time (nearly three years) he has continued to pass a good stream, which is gradually becoming better and better, and has never suffered from retention or any other inconvenience since.

In the present paper we have simply stated what the current, properly applied, will accomplish in stricture of the urethra. We have a large number of cases we could report of patients now living and in the enjoyment of perfect health, relieved of organic stricture and *permanently cured* by electrolysis. We have not said anything about *failures* in treating cases by electrolysis. This is not our object and does not concern us in this article. Our object is simply to show that electrolysis *is capable of permanently curing the worst strictures of every grade and character*, whether in the membranous or pendulous urethra. That there are, and will be, failures by this method we are willing to admit, but were we to trespass further upon the space allowed and the patience of our readers, we could easily demonstrate that the fault, instead of being chargeable to the method employed should be laid upon the shoulders of bunglesome and unskilled operators, who, like faulty mechanics, are ever ready to blame their tools.

RICHMOND, VA.

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### Correspondence.

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#### Priority in the Matter of the Destruction of the Hair Papilla by Electrolysis.

To the Editor of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES.

SIR :—Some days ago I had the pleasure of receiving several valuable reprints from Dr. Brocq, your able Paris correspondent. Turning to the one entitled "De la Destruction des Poils par l'ectrolyse," I observed that he had

given the honor of the discovery to his countryman, Prof. Léon Le Fort, stating that the latter had anticipated Dr. Michel by two years. I immediately wrote Dr. Brocq, showing him that, unintentionally, he had done my friend and colleague great injustice. I have no doubt that he will make a due public correction of his mistake; but as this statement has been repeated in the July issue of your journal, please allow me to present the true facts in the case for the benefit of your readers. Dr. Brocq claims that Professor Le Fort's publication was made in 1877, and Dr. Michel's not until 1879, the former writer naturally has the priority. Unfortunately, however, Dr. Brocq's premises are incorrect, thereby vitiating his conclusions. On the contrary Michel's first article on the subject was printed in the *St. Louis Clinical Record*, October, 1875. I was editor of the magazine at that time, and the publication was made at my urgent request, as I was intensely interested in the question from a dermatological standpoint, hoping soon to present the method to my fellow-specialists on account of its value in hypertrichosis. In all likelihood Dr. Brocq got his misinformation from a printer's error in an article of mine contributed to the *Monatsheft f. Prakt. Derm.* (IV. Bd., Nov. 10, 1885), in which October, 1875, is made to read March, 1879. When this mistake was detected I wrote a short note of correction to the editor, but it was never published.

I have made several other corrections of a like nature, at different times, and I trust very much that the question of priority will not again be disputed. Of course, Dr. Brocq's action was perfectly natural and justifiable under the circumstances. I shall take this opportunity of sending you a reprint of Michel's original paper, and also a recent publication of my own (*Medical News*, May 5, 1888), in which I claim the honor of first applying this admirable procedure to the destruction of hairy growths on the *faces of women*. At the same time it must be admitted that Michel, in the paper just mentioned, suggested electrolysis in other regions than about the eyelids, but being an ophthalmologist he had no occasion to put his suggestion into practice.

So far, indeed, is Professor Le Fort from being the originator of this particular electrolytic measure, it may be seen by consulting Piffard's "Elementary Treatise on Skin Diseases," published in 1876, that that brilliant and versatile dermatologist had preceded him by a year, although himself anticipated by Michel by a similar period of time. Very respectfully,

ST. LOUIS, MO.

W. A. HARDAWAY.

## DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

### Influence of Arsenic on the Skin.

MR. HUTCHINSON has raised a very important question by his suggestion made at a meeting of the Pathological Society of London, that the administration of arsenic for many years in full doses may lead to the development of epithelial cancer. Five cases were quoted in support of this proposition. The first was that of a gentleman who had taken arsenic for psoriasis during many years. A corn which appeared on the sole of the foot, ulcerated, having at first the appearance of perforating ulcer. Small corns developed also on the palms of the hands. The growth on the foot was excised and the patient recovered. The microscopical examination was inconclusive. A drawing of the foot was shown.



Another case quoted, was that of an American physician, already published by Professor White, of Harvard University, and of which Mr. Hutchinson showed drawings. The patient had taken arsenic for long periods to cure psoriasis, and though this was effected, a rough condition of the palms and soles appeared, with small growths which Mr. Hutchinson regarded rather as corns than warts. Ultimately ulcerative lesions appeared, for which the hands were amputated, and after the patient's death, which happened eighteen months later, epithelial cancer was found in the axillary glands and in the internal parts.

The third case was one in which arsenic was taken for a cancerous growth in the neck, and in which, therefore, the arsenic could not be considered the cause of the cancer. But after taking the drug in large doses for some months, the patient who had previously had no skin disease, began to show a thick muddy condition of the skin, while patches like psoriasis developed upon the elbows and other parts, and masses like corns appeared on the palms and soles, but were not followed by cancer.

The fourth case was that of a young lady who had taken arsenic for pemphigus, with occasional intermissions, for several years. An ulcer developed on the crest of the ilium, enlarged glands and a tumor followed, from which the patient died at the age of 25.

The fifth case was that of a clerk, aged 34, with psoriasis; who had taken arsenic for a long time. The palms and soles were speckled over with corns when he applied at the Skin Hospital. Finally epithelial cancer of the scrotum appeared and was excised. The patient was then lost sight of.

Sir James Paget, the President, thought that in face of these facts, it could not be doubted that arsenic had a power of determining the development of cancer in persons predisposed to it.

Those who do not go quite so far as Sir James Paget, will admit that the facts collected by Mr. Hutchinson are suggestive, and call for further investigation.

A case of a more usual result of the administration of arsenic was reported to the Clinical Society by Dr. Handford. A child aged 13, affected with chronic pemphigus was treated with 15-minim doses of Fowler's solution three times a day for ten weeks. After this the skin of the whole body was noticed to be dry, brawny and darkened. The axillæ, groins and abdomen were almost as dark as in Addison's disease. The color was due to pigment, deposited chiefly in the rete, but partly in the superficial epidermis. On the hands and feet were also seen elongated patches of thickened and elevated cicatricial-looking skin. These patches were covered with white points just beneath the epidermis, in size and appearance resembling to the naked eye, miliary tubercles. They consisted of accumulations of degenerating epithelial cells in the deeper part of the epidermis. When the arsenic was discontinued and the skin treated with wet packing, the skin resumed its normal smooth appearance in a month and much of the pigmentation had disappeared. The cicatricial patches on the hands and feet disappeared in four or five months.

These changes were considered to be due to the use of arsenic.

Several members of the society confirmed the fact of the occurrence of pigmentation after arsenical treatment on the site of the eruption for which arsenic was given; as indeed has been very generally observed. Cases were also quoted of general pigmentation though of less frequent occurrence,

from the same cause. Dr. Radcliffe Crocker thought it was probably due to a deposit of metallic arsenic in the skin.

Comparing the description of the tubercle like, epidermic bodies with Mr. Hutchinson's account of "corns" in the epidermis, in the cases reported by him and also attributed to arsenic, it would appear that they refer to the same or similar structures, and the probability that both were due to arsenical treatment is confirmed. (*Reporter.*)

#### **Treatment of Eczema and Psoriasis by the Harrogate Waters.**

Dr. Myrtle, of Harrogate, introduces his remarks on this subject by expressing his belief that both these diseases are becoming more and more common, and alleges, as a proof of this conclusion, the increase in the number of dermatologists. He reports three cases of very severe and universal eczema treated by baths of the alkaline sulphurous waters of Harrogate. The gravest case, that of an old man of 70, completely covered with eczema, was treated with baths at 98° Fahrenheit, and subsequent application of cotton wool medicated with a preparation of coal tar. He was cured in six weeks. Three very severe cases of psoriasis were cured by similar treatment in periods of from three weeks to three months.

It is worthy of note that though Dr. Myrtle formerly used warm baths, from 96° to 104°, he found them of little service, and now employs them always as cold as they can be borne. The patient must, however, be strong and sound in all his organs, otherwise this treatment is attended with some risk.

Dr. Spender, of Bath, puts in a similar claim for the efficiency of the Bath waters in the treatment of general psoriasis, though he admits that local eruptions of the disease are best treated by local remedies.

#### **Counter Irritation in Eczema.**

The treatment of eczema is a subject of inexhaustible interest, and we may refer to Dr. Radcliffe Crocker's valuable observations on treating obstinately recurrent eczema by counter irritation over the vasomotor centres. Among the cases which he quotes is one of an eczema of three months' duration, affecting the scrotum and thighs, treated by the application of a mustard leaf over the lower dorsal and lumbar spine, and cured in three weeks by five applications. In another case acute exudative eczema of the face and arms was treated by mustard applied to the nape of the neck. The face was speedily and effectually relieved, the arms later on. Dr. Crocker does not claim that this method is generally applicable, and in the case of a more universal eruption it is obvious that it might aggravate instead of relieving the disease. (*Lancet*, II., 1192, 1887.)

#### **Communication of Syphilis by Tattooing.**

This is among the rarer accidents by which syphilis may be acquired. Dr. Grenville Moffet records, however, three cases in soldiers. It is supposed that the needles used in the operation must have been previously used for other men affected with syphilis. The incubation period appears to have been long, and the symptoms were mild the affection having been probably derived from the secondary stage of the disease. (*Lancet*, II., 910, 1887.)

Another instance of the communication of the disease by tattooing is given by another army surgeon, Parker (*British Medical Journal* II., 1277, 1887). In this instance the syphilis was communicated from the

soldier who acted as tattooer, and apparently in consequence of the unpleasant practice of spitting on the wound during the operation. Dr. Carleton (*ibid* p. 1879) gives a similar instance from another regiment. In the latter case it was established that the tattooer who gave the disease to his subject was suffering from symptoms of the tertiary stage, which shows that saliva in that stage of the disease may be contagious.

#### Lardaceous Disease in Congenital Syphilis.

Though acquired syphilis is a recognized cause of lardaceous (or amyloid) degeneration, Dr. Hale White's case, reported to the Pathological Society of London, is probably the first in which congenital syphilis has produced this condition. A girl, aged seven, both of whose parents had had syphilis, presented most of the signs of the congenital disease, and, in addition, great enlargements of the liver and spleen. The left eye showed disseminated choroiditis and optic neuritis; the glands in the right axilla were enlarged, and there was a painful node over the head of the tibia. The urine was albuminous. After the death of the patient, which occurred from acute tonsillitis, the liver was found very large, hard, and partly cirrhotic, with radiating fibrous depressions all over it, and containing a gumma the size of a walnut. It was extremely lardaceous, as were also the spleen and kidneys, and, in a slighter degree, the cervical glands and small intestine. There were indications of old peritonitis, but no sign of suppuration in any part. This case showed three very rare manifestations of congenital syphilis; first lardaceous disease; second, chronic peritonitis; third, fibrous scars and a gumma in the liver, in addition to cirrhosis.

#### Late Hereditary Syphilis.

There can be little doubt that the recognition of hereditary syphilis after the age of infancy will lead to a correct interpretation of many cases as yet obscure.

One in a woman, aged 45, is recorded by Dr. Brooks, of Manchester. The syphilitic symptom was a very large gummatous tumor of the buttock, which had been present almost from birth. The patient had borne four healthy children, and there was no direct evidence of syphilis, so that the diagnosis does not appear absolutely certain. (*British Medical Journal*, II., 1839, 1887.)

#### Molluscum Fibrosum.

A remarkable case of this affection combined with a large pendulous fibroma, has been described by Dr. Ledard. (*Lancet* II. 63, 1887).

A middle-aged man had the upper two thirds of the body covered with numerous cutaneous tumors, some freely moveable, some fixed, from the size of a split pea to that of a chestnut. They had been gradually coming for years, and it was impossible to say how long they had been present; the patient had also a large pendulous tumour hanging down like a satchel, attached to the skin over the left iliac crest, and left inguinal and lumbar regions. It was ten inches long and fourteen inches wide at its attachment. When removed it was found to weigh six pounds.

This tumor had existed from birth, and had grown till the man was 24 years old, since which time it had ceased to increase. On microscopical examination it was found to consist of soft white fibrous tissue with spindle-shaped, oval and round cells, in fact a fibroma. There was

some glandular tissue, but no evidence of morbid activity of the sebaceous glands.

No reference is made to the presence or absence of nervous structures in these tumors as observed by Von Recklinghausen, but there was evidence of imperfect cerebral development, as often noticed in such cases. The man had never been what is called "quick" though his head was large. He was regarded as having some mental deficiency. His employers said of him that he "could do what he was told, but he would never make a skilled workman, as he had no ideas."

#### Pemphigus after Parturition.

Mr. O. Croft (*Lancet* II., 858, 1887), reports the following case: A healthy woman aged 37 who had had twelve children, broke out on the fourth day after her confinement in an eruption of pemphigus composed of large blebs. The attack lasted five or six weeks, and was unaccompanied by fever.

The patient had suffered from the same disease after three previous confinements; the attack usually beginning on the fourth day after delivery and lasting several weeks, but all the previous attacks had been more severe than the last.

It seems difficult to draw the line between this form of pemphigus, and hydroa gestationis, or herpes gestationis, which affection has been observed to occur after parturition as well as during pregnancy.

#### Treatment for Warts.

Mr. B. G. Pullin (*Bristol Medico-chirurgical Journal*, December, 1887), reports several cases of multiple warts on children and young persons treated by two minims of liquor arsenicalis (Fowler's solution) thrice daily. In all the warts began to fall off in about a week and a complete cure was effected in two weeks.

#### Pruritus Vulvæ.

This troublesome affection was treated by Simson, and it is said successfully, with an ointment composed of thirty grains of cocaine to one ounce of lanoline. The case was that of a diabetic old lady, and had resisted other methods of treatment. (*Lancet* II., 520, 1887.)

#### Lumbar Hypertrichosis.

The excessive growth of hairs in a patch on the loins, known by this name has of late excited attention, especially since the condition was shown by Virchow to be in some cases associated with a defect of the posterior arches of the lumbar vertebræ called by him *spina bifida occulta*. Mr. J. B. Sutton has lately described a case bearing on this subject and quoted some of those previously reported. His case was that of a girl aged 15, who suffered from a perforating ulcer of the sole of the foot and caries of the metatarsal bones, for which amputation was performed. Subsequently ulceration of the stump rendered reamputation necessary, and on examination there was found to be a soft depressed spot over the third and fourth lumbar arch indicating deficiency of the vertebral arches at this point. There was observed also an abundant crop of fine downy hairs radiating from the soft spot as from a centre, which, though the hairs were not long, indicated the same condition as the more abundant hairy growth seen in more pronounced

cases. This hairy growth, the perforating ulcer and the subsequent ulceration of the stump were regarded as consequences of the spinal malformation.

A much more pronounced case of hypertrichosis in a girl 6 years old is reported by Dodd (*Lancet* II., 1063, 1887), in which there was a development of hair like that of the head in the region of the loins on both sides. The longest hairs measured six and one-half inches. There was no evidence of spina bifida or other disease.

As a curious instance of the length to which hairs may grow, we have a report of the hair taken from the head of a Dacoit (or brigand), executed in Burmah, which was brought home by an English soldier. The extreme length was sixty-seven inches.

LONDON.

J. F. PAYNE.

## DERMATOLOGY AND KINDRED STUDIES IN GERMANY.

### A New Method of Treating Torpid Ulcers.

DR. F. SPÄTH (*Centralblatt für Chir.*, No. 14, 1888), says the principal reason for the faulty healing and want of proper cicatrix formation in torpid ulcers, depends upon the imperfect blood supply to the borders, which are usually composed of calloused connective tissue. Upon such a poorly vascularized base, only weak and flabby granulations can spring up. The same conditions prevail if the base of the ulcer is composed of a fascia. The new method of treatment proposed by Späth, consists of free division through the ulcer's borders and into the sound skin, so that the cut edges gap far apart. When the blood flow has been well stopped and an iodoform permanent dressing applied to the wound, an abundant granulation formation takes place which very quickly leads to cicatrization of the ulcer. In such cases as this the result of cutting around the ulcer, as well as transplantation, are equally ineffectual.

### The Treatment of Abnormal Developments of Epidermis; Callosities, Corns and Warts.

Roesen (*München Med. Wochens.*, No. 28, 1888) following Nussbaum's suggestion, has employed salicylic acid in substance instead of dissolved in collodion, applying it as a powder upon the lesions in question, and covering with moistened bandages. The results have been very good. The method consists of the following procedure: The lesion to be treated is first made moist with an aseptic solution, and then covered with quite a thick layer of salicylic. Over this is placed some of the finest borated lint in four thicknesses, and the whole is bound down with a piece of gutta-percha. This dressing is to remain, in ordinary cases, for five days without being disturbed. After the dressing is removed the pathological process is found easily and painlessly cured and without any bleeding. In more obstinate and harder lesions the dressing must remain on for ten days, or after five days be renewed.

### Accidental Syphilitic Infection.

Koch relates in the *Wiener Med. Blätter*, No. 52, 1887, that a 31 year old civil engineer wounded his finger with a drawing instrument, about the last of May. The wound healed very slowly and the delicate cicatrix often broke open. In the middle of July there were enlarged glands in the region of the elbows, followed by swelling of the glands of the axilla and of the

neck. Somewhat later an eruption of small papules upon the trunk, and a psoriasis palmaris et plantaris. Catarrh of the throat, and painful swelling of the frontal periosteum and of the mastoid process, completed the picture of universal syphilis. The negative evidences of disease on the part of the penis, the glandular swellings of the arm, the occurrence of an injury to the finger, made the site of the primary lesion sure. It is probable that the poison was upon the instrument which caused the wound, for designers and draughtsmen are often in the habit of holding the instrument in the mouth before sticking it into the paper.

#### **The Condition of the Spleen and Kidneys in Early Syphilis.**

Schuchter, according to the *Wiener Med. Blatter*, No. 42, 1887, has examined twenty-two cases, partly in those still having the primary lesion, and partly in those already showing the general manifestations, but all having recent syphilitic manifestations, to discover the condition of the spleen and kidneys. In six instances he found an increase in size of the spleen which could be attributed to syphilis, and albuminuria was discovered in two cases.

#### **Chloroform in Drug Solutions.**

Unna speaks of chloroform water in solutions of certain medicaments (*Monatshefte für prakt. Derm.*, No. 9, 1888). Since chloroform possesses anti-mycotic properties, he recommends it as an addition to such drug solutions as are easily spoiled by becoming mouldy. Thus Fowler's solution can be kept either for internal or subcutaneous use when a few drops of chloroform are added. No unpleasant consequences were noted from its use, excepting a slight burning at the point of insertion, and this even was absent when injection was made in the gluteal region.

#### **General Treatment of Syphilis.**

Trost (*Wiener Med. Wochens.*, No. 18, 1888) recommends gray oil (*oleum ciner*), a preparation which is used in Professor Lang's clinic in Vienna. It is prepared in the following manner: Equal parts of metallic mercury and lanoline are rubbed together until complete extinction of the mercury particles, and to six parts of this salve is added four parts of olive oil, and the whole well rubbed together and kept in some cool place. The oil from this mixture is taken. The greatest cleanliness and care must be employed by both the druggist in making the oil and by the physician in using it. The author employs a syringe of half a cubic centimeter capacity and a very sharp needle. The cylinder and needle as well as the piston must be carefully cleansed with carbolic water.

There are to be weekly three-quarters of a syringe of oil injected in two different places. When the general symptoms have disappeared, there must be still an injection of 0.6–0.9 cubic centimeters, as an after cure. As points for injection the nates and back will be chosen. The author says that since he has mastered the technic he has neither had abscesses nor painful infiltrations follow the injections.

#### **Action of Mercury Upon the Bowels.**

Kraus writes, in the *Deutsch Medicin Wochenschr.* No. 12, 1888, upon our present knowledge of the influence exerted by mercurial preparations upon the intestinal track. The following case resulted from the use of large

doses of mercury in the form of subcutaneous injections : A 30 year-old workman presented himself with a recent syphilis and an infecting lesion on the penis, and received a calomel injection (according to Neisser) of 0.1. Seven days later a second equally strong injection was made. On the next day an extensive swelling of the mucous membrane of the mouth and cheeks appeared, and during the next few days, in spite of all treatment employed, only increased and took on a chocolate color, on account of extravasated blood. Furthermore, bloody stools, vomiting and anuria came on. Under the increase of bloody stools, and the unchanged condition of the other symptoms, the patient fell into a comatose condition, and died six days after the second injection of calomel. The autopsy showed dysentery of the bowels, rupture of the sigmoid flexure, peritonitis, and nephritis acuta parenchymatosa.

Now it is a well-known fact in literature that mercury may produce this form of intestinal manifestation, and as this patient was previously quite well, the clinical diagnosis of acute mercurial poisoning is entirely tenable.

#### A Case of Double External Urethrotomy.

Gärtner relates in the *Deutsch. Zeitschr. für Chir.*, 5-6, 1888, the case of a young theologian who, a few years before, had introduced five v-formed hooks by their rounded end into the urethra, and had presented himself seeking their removal. Since their introduction there had been a slight discharge of pus, but the flow of urine and the generative functions had remained undisturbed. In the perineum, just behind the bulbus, was to be made out a foreign body, which could be felt and rubbed together. In the same way could be felt, just behind the external orifice, another foreign body. A silver catheter passed by the foreign bodies, and entered the bladder. Attempts to remove the foremost foreign body by the aid of forceps and an elastic catheter were fruitless. External perineal urethrotomy was therefore resorted to and four hooks at once removed. The other hook could not be extracted from this opening, so a new cut was made in the urethra and the hook removed. An elastic catheter was introduced, the wounds carefully cleansed, and after a few days dressed with basilicon ointment; complete healing took place without any bad symptoms.

HOROVITZ.

VIII. ALSERSTRASSE 15,  
VIENNA.

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## Selections.

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### BITUMINATE OF IODOFORM.

THE application of iodoform is a favorite method of treatment of chancres with many, but there are certain disadvantages attached to it which sometimes render its use impossible. These are, in the first place, the disagreeable odor which often shuts off the patients under treatment from the society of their fellowmen; secondly, the drug is not well borne by every one, and it occasionally excites an erythema or an eczematous eruption which compels its withdrawal; and thirdly, in ulcers with overhanging edges, the use of iodoform sometimes excites such exuberant granulations that they

spring up and press against the undermined edges of the ulcer, preventing the escape of pus formed beneath. Dr. S. Ehrmann writes in the *Centralblatt für die Gesamte Therapie*, for July, 1888, that he had long sought to obviate those disadvantages, and finally lighted upon a mixture of iodoform and tar, which seemed to answer the purpose admirably. After a long series of experiments, he succeeded in combining these two substances in such a way that a new preparation was formed in which the particles of iodoform and tar were so intimately mixed that under the microscope only hyaline plates were to be seen, the characteristic crystals of iodoform being not at all, or only indistinctly, recognizable. This bituminate of iodoform, as it has been called by the writer, is a substance somewhat resembling mica, consisting of translucent and transparent scales of a brownish metallic color, which are easily pulverizable. The characteristic odor of iodoform is wholly absent, and only a slight, mildly aromatic, and not unpleasant smell of tar is perceptible. This is so faint that it is noticeable only when a large quantity of the substance is present, and even this may be covered by mixing a mere trace of liquid storax with a large quantity of the powder. When the preparation is shaken up with a large amount of water the odor of iodoform returns, but water in small quantity does not have this effect. From this it follows that in wounds having a very profuse secretion the application might not be strictly odorless, yet the author says he has used it in the case of a very extensive bubo, and after two days there was no odor perceived by either the patient or those about him. Dr. Ehrmann has used the bituminate of iodoform with success in the treatment of soft chancres, especially phagedenic, as a dressing, after the opening of suppurating buboes, in gummy tumors and in ulcers of the leg. The powdered substance is applied to the ulcer and covered with a thin layer of wadding, over which is placed the ordinary dressing. The dressing is changed every twenty-four to forty-eight hours. In the case of soft chancres which are so situated that the dressing becomes saturated with urine, or which secrete profusely, it may be necessary to renew the dressing twice daily.

### SALICYLATE OF MERCURY.

DR. K. SCHADEK has made a number of experiments to test the efficacy of salicylate of mercury in gonorrhœa and syphilis, as recommended by Silva Arango, and comes to the following conclusions: 1. Salicylate of mercury, as an anti-syphilitic remedy is not less active than the hitherto employed preparations of mercury; it is well adapted to the treatment of secondary syphilis, and internally administered, causes the rapid disappearance of the milder syphilitic symptoms, and is also very useful in the after treatment of the disease; when employed in the form of intramuscular injections the remedy caused an entire disappearance of the symptoms. 2. Contrary to what occurs with other mercurial preparations, this remedy produces no unpleasant local effects, and no symptoms of irritation or of systemic disturbance follow its use, notwithstanding the fact of its insolubility; in this respect it possesses a great advantage over the other mercurials. 3. The external use of salicylate of mercury is very useful in various forms of syphilitic infiltration, causing their resorption. 4. In acute and subacute gonorrhœa it also acts favorably; the secretion rapidly diminishes in amount, and the other inflammatory symptoms subside. The remedy is not, however, always effective.—*Monatshäfte für Praktische Dermatologie*, No. 10, 1888.



### THE KREUZNACH MOTHER-LIQUOR AND CALCIUM CHLORIDE IN THE TREATMENT OF SKIN DISEASES.

IN studying the action of the Kreuznach mother-liquor, Dr. E. Lier has come to the conclusion that its efficacy depends upon the chloride of calcium, which it contains in the proportion of 345.41 parts per thousand. He has found that applications of the mother-liquor may exert two different effects, viz., a primary or superficial, and a secondary or deep effect. The first is adapted to the treatment of erythema, moist eczema, impetiginous affections, psoriasis, and tubercular glands. This effect is obtained by cool baths (not over 90° Fahrenheit) of short duration, with or without the addition of mother-liquor and applications of a paste of oxide of zinc and terra silic. aa 50.0, vaseline 150.0, mother-liquor 250.0. The deeper effects are obtained by warm baths (93° to 99° Fahrenheit) of longer duration, with the addition of a large quantity of mother-liquor, and also by compresses of the same, either pure or slightly diluted. These are indicated in pruriginous and keratoid eczema, ichthyosis, scleroderma, and all forms of skin diseases in which there is much infiltration or induration of the cutis. He has also used calcium chloride alone in a similar way. He does not, however, go into the details of the treatment which, he says, must vary in individual cases according to the anatomical, physiological and pathological conditions of the skin.—*Centralblatt für die Gesamte Therapie*, July, 1888.

### THE PREVENTION AND TREATMENT OF BLENNORRHOEA NEONATORUM AND GONORRHOEAL CONJUNCTIVITIS.

DR. F. E. D'ONCH, read a paper with this title before the Society of German Physicians (*New Yorker Medizinische Presse*, July, 1888), in which he insisted upon the importance of the prophylaxis of these affections, now known to be one and the same disease. The symptoms of gonorrhoeal ophthalmia vary greatly in severity, the course of the disease being sometimes so mild that the danger is over within a few days, at other times so severe that the eye is soon destroyed despite the most painstaking care. The period of incubation has not been definitely fixed, but it is probable that the first clear symptoms of the disease show themselves within twenty-four hours after infection. The first symptom is infection of the conjunctiva followed by the secretion of a tenacious, yellowish mucus, like that of acute conjunctivitis. There is also a feeling of heat and dryness accompanied by a burning and heaviness, the latter due to commencing oedema of the lids. This oedema which is most marked in the upper lid, and also the oedema of the conjunctiva of the ball which is noticed in many cases, is one of the most important diagnostic points in differentiating between gonorrhoeal and ordinary acute conjunctivitis. In the latter, however intense it may be, there is at the most a slight swelling of the lids, but never oedema of the conjunctiva bulbi. The latter may, in the gonorrhoeal variety, assume immense proportions. The secretion is for the most part muco-purulent, and, in the more favorable cases, rather thick and yellowish, when the discharge is thin, the prognosis is less favorable, as the cornea not infrequently becomes involved in such cases. In this involvement lies the greatest danger for the eye, but as long as the epithelium covering the cornea remains intact the outlook is favorable. If an ulcer once forms, however, it may spread with astonishing rapidity and soon destroy the entire cornea. In many cases both eyes are

affected, the second a couple of days after the first. Usually the left eye is the first attacked. If seen early enough, an attempt should be made to prevent the infection of the second eye by a protective bandage, although, in the case of a very intelligent patient, this may be dispensed with. The patient should lie on his back or on the side of the diseased eye so as to prevent any dripping of the secretion into the sound organ, a separate towel must be used for each eye, and the most minute cleanliness must be observed.

As to treatment, the author regards constant cold applications as the best. It has been shown that the gonococcus develops very slowly or not at all at a temperature of 30° Centigrade (86° Fahrenheit), so that if it is possible to keep the temperature of the conjunctiva depressed to this degree, a very important point is gained in the struggle with the disease. This is best accomplished by compresses of four layers of linen, cooled on ice, and changed twice in the minute. In the acute stage, when the inflammation of the lids is increasing, a very considerable amount of heat is produced, so that the applications must be renewed more frequently. Later, when the inflammation is decreasing, the application of the compresses must be carefully regulated, otherwise there is danger of cooling the cornea down to too low a point. This is indicated by a cloudiness of the surface, which, however, soon clears up when the cold is withdrawn. The compresses must be kept on night and day for, usually, about five days, for if they are left off for any length of time the development of the gonococcus again takes place.

Lotions are of little benefit in the beginning, except that they remove the secretions and keep the eye clean. The attempt to destroy the micro-organisms by means of antiseptic solutions is attended with little success, by reason of the fact that they cannot be used in sufficient strength, and also because they can act only superficially and are powerless to destroy the microbes in the deeper tissues. For cleansing purposes a four per cent. solution of boracic acid, or one of bichloride of mercury, 1-5,000, may be used. Great care must be taken, in the removal of the secretion, to avoid injury to the corneal epithelium. A soft camel's hair pencil may be used to remove the secretion that is not washed away by the fluid. The author does not approve of nitrate of silver solutions in the early stages of the disease, though later they may be of great service in hastening resorption.

Fortunately, gonorrhœal ophthalmia is a comparatively rare disease, when the frequency of urethritis is considered, but it nevertheless devolves upon the physician treating a case of the latter disease to warn his patient urgently of the danger of transferring the affliction to the eyes.

Blennorrhœa of the new-born, presents a similar clinical picture. The swelling of the lids varies greatly in the different cases. The secretion is usually more creamy and is often very profuse, so that it is sometimes astonishing how such a condition can exist for weeks without injury to the cornea. The treatment of the disease is to be conducted on the same lines as that of gonorrhœal ophthalmia, and the best results are obtained by means of cold compresses and the observance of great cleanliness. It seems a simple thing to make cold compresses, but one has only to observe how it is attempted to change his views on this point. Sometimes one sees a big piece of cloth covering the cheek as well as the eye; at another time he sees a lump of ice wrapped in a thin fold and applied directly to the eye, thus running the risk of freezing the cornea; or again, and more commonly, the applications are

changed so seldom that they act as warm rather than cold compresses, and do much more harm than good. They should be renewed constantly, day and night. When the acute stage of the disease is past, and the secretion begins to become more scanty, the cold applications can be dispensed with, but cleanliness must still be insisted upon, and this is obtained by gentle rubbing and irrigation. Of course, the greatest care should be observed to prevent injury to the cornea, for the safety of the eye depends upon this. Ulcers, when they occur, begin usually near the centre of the cornea, and when once the destruction process has begun, it can only with the greatest difficulty be controlled.

Measures for the prevention of blennorrhœa neonatorum have been instituted successfully only in recent times. These consist in destroying the virus after its entrance into the conjunctival sac, or in removing it from the genital tract of the mother before the birth of the child. The first object is obtained by the well-known Credé's method, of the instillation of a two per cent. nitrate of silver solution; the second, by vaginal injections of corrosive sublimate, carbolic acid, etc. The value of Credé's method is shown by the fact that since its introduction into the practice of German lying-in institutions, ophthalmia of the new-born has become almost unknown. A two per cent. solution of argentic nitrate is sometimes productive of very great irritation, and a half of one per cent. solution has been found to be equally efficacious. The second method, of vaginal injections, has found great favor in recent times, and has been shown to be of great value, but it is practicable only in lying-in institutions, and for private practice Credé's method is to be preferred. In private practice these cases are rare, yet each case that does occur is one too many, and every one ought to do all in his power to promote the more general adoption of Credé's method. Midwives especially should be made acquainted with it, and should be induced to practice it, since it is as simple as it is free from danger.

#### **ON THE SURGICAL TREATMENT OF SUPPURATING VENEREAL BUBO.**

In a quite lengthy article on the subject of surgical treatment of bubo, Dr. Karl Szadek gives the results of his observations at the Military Hospital of Kiew (*Vierteljahresch. für Derm. und Syph.* No. 2, 1888). He reviews the treatment employed in ancient times and finds that it is only of recent years that decided progress has been made. The present method of treatment at the Kiew hospital, was instituted by Dr. Fleischer in 1880, and the good results obtained by both Dr. Fleischer and the author himself has led him to publish them. Before speaking of the method employed, the author makes an exhaustive resumé of the different modes of treatment in vogue since the Fifteenth Century, showing how some surgeons sought to prevent suppuration whilst others looked upon a discharge of pus as wholesome, and encouraged it to rid the system of so much "syphilitic poison." Most physicians at the beginning of the Nineteenth Century believed in causing resolution of commencing venereal buboes, and whenever possible to prevent suppuration. Fomentations and cataplasms with strong solutions of acetate of lead were used by Goulard and others. Fricke first employed constant pressure. Fergusson warmly recommended compresses which were favorably received by Ricord and others, but it met with great opposition. Treissel and Patzelt modified the method, and it was again taken up. Zeissel had excellent re-

sults in aborting buboes with the aid of acetate of lead, and Petzelt also caused resorption in a large proportion of cases. As a derivative remedy for preventing suppuration, the tincture of iodine was introduced by Lallemand and highly recommended by Sigmund and others. Roux recommended early puncture of the bubo, followed by injection of iodine (1 to 60), or corrosive sublimate (1 to 100). Eiber recommended daily injections until the suppuration ceased. Scott Holm, after puncturing the bubo with a special syringe, injects a carbolic solution, followed by an emulsion of iodol in castor oil. Out of twenty-three cases of bubo thus treated, he had good results in twenty-two. Waller, Taylor and others recommend for buboes which have not yet suppurated, an injection of carbolic acid into the gland; one injection usually suffices to prevent suppuration.

Auspitz does not believe in absorptive methods, and Zeissel in the last edition of his work says methods for the prevention of suppuration in buboes due to soft chancre very seldom succeed. Most authors open the bubo with the knife, some extending the cut the whole length of the abscess cavity, while a few use Vienna paste or recommend a small puncture. Others have employed multiple puncture; drawing off the pus by means of a trocar and canula; pumping out pus through a subcutaneous opening; aspiration; drawing off with a Pravaz syringe, etc. Pick was the first to use iodoform in a methodic way in the treatment of open bubo, and since then the iodoform dressing has been the most approved treatment after incision. The usual procedure is to open the bubo, scrape out the remains of the glands with the finger or with a Volkmann's spoon, wash out with carbolic or corrosive sublimate solution, and after the bleeding has been stopped, to dust in iodoform and apply an occlusive dressing.

Quite recently a method by total excision of all enlarged inguinal glands tending to suppurate has been introduced, but the author does not recognize in it any advantages over the method by incision, scraping out and heating with iodoform or iodol, which in the hands of Pick brings about healing in an average of sixteen days. In this review of the literature, to which we have not the space to do justice, the author refers to the writings of no less than 150 observers, from which it is manifest that the advances in therapeutics are of recent date. The reason for the great dread in which bubo was held in olden times and the gravity of the prognosis must be sought for in the faulty methods of treatment and the want of antiseptics. Now with the employment of carbolic, salicylic, sublimate, iodoform or iodol we can make large incisions, scrape out and remove glands, etc., without danger. The after treatment is now much simplified by the infrequent changes of the occlusive dressing. The number of cases observed by the author is 274, all seen during the past five years in the Military Hospital at Kiev. During the same period 1,084 cases of soft chancre have been treated or one bubo to about every four of chancreoid. The site of the chancreoid influences the production of bubo to a great extent. Thus when situated at the frænum or upon the inner surface of the prepuce bubo is frequent because of the richness of these parts in lymphatic vessels which are connected with the inguinal glands. In thirty-eight cases there was bubo of both sides, and these double buboes occurred for the most part where the sore was at the frænum. The chancreoid bubo appears mostly from three to four weeks after the appearance of the sore, at times two weeks or so after it has healed. From the beginning of the bubo till it is opened there is a lapse of from two

to three weeks (acute phlegmonous adenitis in healthy individuals), more rarely from four to eight weeks (in anæmic and scrofulo-tuberculous persons).

The method of treatment carried out in the Kiew Hospital is as follows: In beginning bubo, so long as there is no fluctuation, or redness of the skin, simply rest and prevention of irritation or injury to the inguinal region, at the same time appropriate treatment is employed for the soft sore.

If the skin is reddened but fluctuation not yet well established over the whole abscess, hot compresses, made with a carbolic solution are to be applied until there is established complete suppuration of the swelling. Painting with the tincture of iodine does not meet with favor. As soon as fluctuation is made out in the whole abscess and it is ripe, a surgical opening is necessary. A mild degree of chloroform narcosis is recommended, as the necessary steps are very painful. After most careful cleansing of the skin in the inguinal and genital regions and the thigh, as well with soap, brush and warm water and shaving off the hair of the pubes, the operation field is to be disinfected with a five per cent. carbolic, or a one per cent. sublimate solution. A free opening is then made, in most cases parallel with Poupart's ligament, by means of a small bistoury. The incision must correspond with the length of the bubo. After evacuating the contents any recesses or sinuses are to be separated by means of a pair of scissors and all glands, both those which have suppurated and others which are enlarged, must be removed with the finger, and remnants of glands and firm granulation tissue scraped out with Volkmann's spoon. If an affected gland does not yield, its capsule must be opened with the knife and its contents removed. If the cutaneous covering is destroyed in a large area it is best to cut it away with scissors. It was only necessary in a single case to apply a ligature on account of hemorrhage. After the bleeding has been stopped with cotton-tampons the cavity is to be washed out with a corrosive sublimate solution and the whole cavity sprinkled with iodoform alone or mixed with alum, packed with iodoform gauze and an occlusive dressing applied. The latter consists of a few layers of sublimate gauze and salicylic or sublimate cotton, upon which a mass of jute or tow is placed. The whole is then covered with mackintosh or glazed paper and fixed with turns of a moist, wide dressing bandage.

The first permanent dressing when well applied and the patient keeps quiet can remain from two to five days. If it becomes soaked with the secretions it may have to be changed earlier. In the second dressing the edges of the wound are washed with a five per cent. carbolic or a one per cent. sublimate solution, the wound covered again with iodoform without washing out the cavity or applying tampons, and a fresh dressing applied. This and following dressings can, with few exceptions, be left from five to ten days and changed only if oozing is noticed from the edges. Besides the 274 chancroidal buboes there were treated during the same five years twenty-six syphilitic buboes, and twelve times the inguinal glands were removed by operation on account of tubercular adenitis. The duration of treatment of chancroidal buboes averaged thirty days. Complications with phlegmon diphtheria. Chancroidal destruction of the walls and edges, etc., were never encountered in the acute or subacute chancroidal buboes. In five cases erysipelas occurred, but it seemed to have little influence on the course of the result as healing always took place. In twelve cases eczema of the neighbor-

ing parts came on, delayed healing from ten to twenty days as the dressing had to be frequently changed. The course of the opened suppurating syphilitic buboes, which were usually not scraped out but had the glands respected, was usually favorable and no complications occurred. In tuberculous adenitis the wounds healed kindly and for the most part quickly when the individual was strong and otherwise healthy, after extensive scraping out and extirpation of the glands. In anæmic and broken down patients, the healing was slower. Although iodoform was employed in large quantities, intoxication from it was never witnessed. In all the varieties the scar was as a rule smooth, even often linear, and after a time scarcely noticeable. The author then gives the histories of twenty of the cases which he treated personally in 1886, but for which as well as for the bibliographical references we must beg to refer the reader to the original.

## Items.

**AMERICAN DERMATOLOGICAL ASSOCIATION.**—Twelfth Annual Meeting to be held at Willard's Hotel, Washington, D. C., September 18, 19, and 20, 1888. Officers for 1888; President; Dr. I. E. Atkinson, of Baltimore; Vice-President, Dr. P. A. Morrow, of New York; Secretary and Treasurer; Dr. G. H. Tilden, of Boston.

### PAPERS.

Address, by the President, Dr. I. E. Atkinson.

1. The Electrolytic Decomposition of Organic Tissues, Dr. G. H. Rohe.
2. The Value of Salicylic acid in Dermatology, Dr. Heitzmann.
3. Hereditary Dermatoses, Dr. J. C. White.
4. A report of four cases of Dermatitis Herpetiformis, Dr. J. E. Graham.
5. Dermatitis Herpetiformis, with notes of three cases, Dr. H. W. Stelwagon.
6. Personal observations on Skin Diseases in the Negro, Dr. R. B. Morrison.
7. Note of a case of *Filaria Medinensis*, Dr. A. Van Harlingen.
8. So-called Acne Anthracoides Iodopotassique. Dr. R. W. Taylor.
9. Note relative to the Vegetative Lesions induced by ingestion of some of the Iodine Compounds, Dr. J. N. Hyde.
10. Notes on some unusual cases of Skin Disease, Dr. W. A. Hardaway.
11. A contribution to the clinical history of Alopecia Areata, Dr. A. Van Harlingen.
12. The non-identity of Lichen Planus and Lichen Ruber, Dr. G. H. Fox.
13. The question of relationship between Lichen Ruber (Hebra) and Lichen Planus (Wilson), Dr. A. R. Robinson.
14. Multiple Pigmentary Sarcoma, Dr. E. B. Bronson.
15. Dermatitis Plantaris and Palmaris, Dr. L. Duncan Bulkley.
16. Raynaud's Disease and Symmetrical Gangrene in Late Syphilis, Dr. R. W. Taylor.
17. The relations of Papillomata to Syphilis and Tuberculosis of the Skin, with report of a case, Dr. P. A. Morrow.
18. Kraurosis of the Vulva (Breisky), Dr. C. Heitzmann.
19. Molluscum Contagiosum, a clinical report, Dr. H. W. Stelwagon.

**AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.**—Second annual meeting to be held at Willard's Hotel, Washington, D. C.,

September 18, 19, and 20. 1888.—Officers: President, Dr. Edward L. Keyes, of New York; Vice-President, Dr. George Chismore, of San Francisco, Cal.; Secretary, Dr. Robert W. Taylor, of New York.

## PAPERS.

- Address of Welcome, by the President, Dr. Edward L. Keyes.  
 Pyæmia as a Direct Sequel of Gonorrhœa, by Dr. Roswell Park, of Buffalo, N. Y.  
 Clinical Observations on Gonorrhœa, with Special Reference to Etiology, Duration, and Treatment, by Drs. John P. Bryson and Edwin C. Burnett, of St. Louis, Mo.  
 Retrojections in Gonorrhœa, by Dr. Edward R. Palmer, of Louisville, Ky.  
 Local Treatment of Chronic Urethral Discharges, by Dr. Frederick R. Sturgis, of New York.  
 On the Relation of the Prostate to Chronic Urethral Discharges, by Dr. J. William White, of Philadelphia, Pa.  
 The Diagnosis and Treatment of Chronic Urethritis, with Demonstrations of Instruments, by Dr. Oberländer, of Dresden, Germany. To be read by Dr. John A. Fordyce. (By invitation.)  
 Connection between Masturbation and Stricture of the Urethra, by Dr. Samuel W. Gross, of Philadelphia, Pa.  
 The Curability of Urethral Stricture by Electricity: An Investigation, by Dr. Edward L. Keyes, of New York.  
 On the Radical Cure of Stricture of the Urethra by Dilating Urethrotomy, by Dr. Fessenden N. Otis, of New York.  
 The Prognosis of Stricture Based on Thirty Years' Death Record at the London Hospital and the Practice at St. Peter's Hospital, by E. Hurry Fenwick, F.R.C.S., of London, England. (By invitation.)  
 Some Points on the Etiology of Stricture of the Urethra, by Dr. Robert W. Taylor, of New York.  
 The Operative Treatment of Hypertrophy of the Prostate, with Stereopticon Demonstrations of Specimens, etc, by Dr. Francis S. Watson, of Boston, Mass.  
 Prostatotomy for Enlarged Prostate at the Age of Forty-two Years, by Dr. Abner Post, of Boston, Mass.  
 The History of the *Filaria Sanguinis Hominis*: Its Discovery in the United States, and Especially the Relationship of the Parasite to Chylocele of the Tunica Vaginalis Testis, by Dr. William M. Mastin, of Mobile, Ala.  
 Clinical Observations on Diseases of the Testicle, by Dr. L. Bolton Bangs, of New York.  
 Case of Removal of Both Testicles for Recurrent Carcinoma, by Dr. Frank W. Rockwell, of Brooklyn, N. Y.  
 Some Points in the Differential Diagnosis of Bladder and Kidney Affections, with Demonstrations of the Cystoscope and Other Instruments, by Dr. Alexander W. Stein, of New York.  
 Demonstration of a Perfected Evacuator and an Improvement in the Method of the Removal of Débris from the Bladder, by Dr. Fessenden N. Otis, of New York.  
 Stone in the Bladder in Connection with Splenic Leuchæmia, by Charles Williams, F.R.C.S., of Norwich, England. (By invitation.)  
 Litholapaxy in Male Children, by Surgeon-Major Keegan, of Indore, Central India. (By invitation.)  
 Case of Perineal Section for Traumatic Retention—Unusual Condition of the Bladder, by Dr. J. Edwin Michael, of Baltimore, Md.  
 Operations on the Kidney, by Dr. William H. Kingston, of Montreal, Canada.

On the Effects of Rapid Changes of Altitude in an Advanced Case of Interstitial Nephritis, by Dr. George Chismora, of San Francisco, Cal.

Case of Nephro-Lithiasis, Complicated with Hydro-Nephrosis, in which Lumbar Nephrotomy was Performed, by Dr. Frank W. Rockwell, of Brooklyn, N. Y.

Malignant Tumors of the Seminal Vesicles : Two Cases with Specimens, by Dr. John P. Bryson, of St. Louis, Mo.

Case of Bowel Ending in the Urethra of a Child Four Weeks Old—Relief by Operation, by Dr. Arthur T. Cabot, of Boston, Mass.

Unusual Case of Urethral Calculus, by Dr. Harvey F. Mudd, of St. Louis, Mo.

The Congenital Anomalies of the External Urethral Orifice, by Dr. C. Kaufmann, of Zürich, Switzerland. (By invitation.)

The Prophylaxis of Syphilis, by Dr. Prince A. Morrow, of New York.

Syphiloma of the Vulva, by Dr. J. Nevins Hyde, of Chicago, Ill.

The Value of the tolerance of the Iodides as a diagnostic of Syphilis, by Dr. J. William White, of Philadelphia, Pa.

And Papers by Dr. Félix Guyon, of Paris, France, Dr. Freund, of Strasburg, Germany, and others.

**INTERNATIONAL CONGRESS OF DERMATOLOGY AND SYPHILOGRAPHY.**—We have received the preliminary announcement of the International Congress of Dermatology and Syphilography, to be holden at Paris in August, 1889. The Congress will meet in the grand hall of the Museum of the Hôpital St. Louis, and the session will continue for one week.

The distinguished Dr. Ricord has accepted the Position of Honorary President of the Congress, and Professor Hardy will discharge the duties of Acting President. The Vice-Presidents will be chosen from among the foreign physicians who take part in the Congress.

The members of the committee are :

M. Emile Vidal, member of the Academy of Medicine, physician to the Hôpital St. Louis.

M. Ernest Bèsnier, member of the Academy of Medicine, physician to the Hôpital St. Louis.

M. Alfred Fournier, Clinical Professor of Cutaneous and Venereal Diseases, member of the Academy of Medicine, physician to the Hôpital St. Louis.

M. Hallopeau, Professeur Agrégé of the Faculty of Medicine, physician to the Hôpital St. Louis.

M. Quinquaud, Professeur Agrégé of the Faculty of Medicine, physician to the Hôpital St. Louis.

M. Tenneson, physician to the Hôpital St. Louis.

Secretary, Henri Feulard, Chief of the Clinic of the Faculty of the Hôpital St. Louis.

The members of the committee invite their confrères in France and foreign countries who are especially interested in dermatology and syphilography to be present and participate in the work of the Congress.

Before the end of the year 1888, the definite announcement will be issued indicating the exact date of the reunion, the names of the participants, the communications promised, the rules and regulations of the Congress.

The editor of this JOURNAL has received the honor of appointment to the position of Secretary of the Congress for North and South America.



JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

OCTOBER, 1888.

No. 10

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**Original Communications.**

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**CASE OF TUBERCULOSIS PAPILLOMATOSA CUTIS, WITH REMARKS  
ON THE RELATION OF PAPILLOMA TO SYPHILIS, LUPUS, ETC. \***

BY

P. A. MORROW, A.M., M.D.

Surgeon to Charity Hospital.

**T**HERE is perhaps no term in Dermatological nomenclature that has been employed in so comprehensive a sense, and with such an elastic application as papilloma. It has been applied to a variety of papillary growths which while possessing certain morphological characters in common, originate under widely different etiological conditions. Under it are included warty formations which develop as a primary process in the skin, and bear no traceable relation to disturbances in other systems or organs, the specific products of a certain zymotic disease, as well as those exuberant growths which occur as a sequence of various pathological conditions, as eczematous ulcers of the legs, lupus, scrofulous and syphilitic ulcers, carcinoma, sycosis, pemphigus and the vegetative lesions which follow the ingestion of the iodine and bromine compounds. As examples of the looseness of our terminology may be enumerated, verrucous papilloma, carcinomatous papilloma, papilloma neuroticum, dermatitis papillomatosa capillitii, zymotic papilloma, verruca necrogen-

\* Read at the Congress of American Physicians and Surgeons, September, 1888.

ica, lupus papillaris or verrucosus, tuberculosis verrucosa cutis, eczema verrucosum, pemphigus vegetans, syphilis vegetans, etc.

The most distinctive feature of this group of diseases consists in papillary proliferations usually in the form of red, granular, fleshy or wart-like excrescences, of which frambœsia may be taken as the clinical type, but while they are more or less closely anatomically related, the conditions under which they arise, their mode of development, their pathological relations, and their clinical significance, present the widest differences.

I shall not attempt to discuss the pathogenesis of these hyperplastic growths further than to say that in that class of papillomata which are recognized as the symptomatic expressive of a pathological state, the papillary outgrowths are not common or specific products, but rather indirect or incidental results. It is probable that the papillary proliferations which follow a chronic inflammation of the corium are more or less closely allied to the giant granulations which develop in connection with the cicatrization of wounds or ulcers. They may be considered as an aberration or deviation from the normal process of granulation in which the papillary hyperplasia has, under the influence of long continued inflammation, external irritation, or perhaps from structural peculiarities of the skin, taken on an exaggerated development.

Practically, it is often impossible to determine from the clinical aspects of a papilloma whether it is primary or secondary, whether the papillary proliferation constitutes an essential part of the morbid process, or whether it represents merely a metamorphic phase or mode of transformation of some pre-existing lesion. The following case I have deemed of sufficient interest to bring before the attention of this Association, not only on account of the rare and unusual development of the lesions, but also on account of the difficulty experienced in identifying it fully with any of the varieties of papilloma to which reference has been made.

This subject of this observation, Antonio Lavigna, æt 30, a native of Italy, was admitted to the Dermatological Ward of Charity hospital February 24, 1888. He is a medium-sized man, of fair physical development and well nourished. His family history good; his parents and one brother are living and in excellent health. With the exception of chills and fever, from which the patient suffered when he was 14 or 15 years old, he

has always enjoyed good health until about two and a half years ago, when his left wrist became inflamed, swollen and suppurating, necessitating its amputation some months later. He has never suffered from any lung trouble and denies all history of venereal disease.

*Condition on Admission.*—The entire nose, the right and left cheeks, the right upper eyelid and upper lip are covered with a mask of thick grayish-black crusts, which, after being softened by oil dressings and removed, revealed the papillomatous condition shown in the accompanying chromo-lithograph. The lesions consisted of an exuberant growth of papillary excrescences, closely pressed together, forming for the most part a uniformly lobulated surface. The hyperplastic growth was strikingly suggestive of a cauliflower in form and mode of vegetation, only the papillary elevations, instead of being glued together and adherent at their free extremities, were separated by minute decussating fissures, through which exuded a thick, puriform, very concrescible fluid, which was quite offensive. The elevation of the surface was irregular, varying from one to three centimetres, being most marked on the circumferential borders of the patch. The outer wall of the vegetations was not surrounded by an infiltrated margin or inflammatory areola, and seemed to project or curl over on the sound skin. Upon pressing or lifting up this overhanging border the vegetations were seen to uprise directly from the healthy skin, the sound epidermis being continued partly up the wall of the papillary growths, forming a sort of elevated epidermic rim or border. The papillary prominences were for the most part club-shaped, a few nipple-shaped, or distinctly acuminate. Upon the extreme edges of the patch they presented a tufted appearance, branching into filiform processes as seen in *verucca digitata*.

To the feel, the vegetations, when freshly deprived of crusts, were of a soft, fleshy consistence, slightly yielding on pressure. When exposed to the air for some time they became dryer and harder; they were extremely vascular, readily bleeding on scratching. The color varied from a bright red to a deeper, raw-flesh tint. The subjective sensations of itching and pain were marked, the patient could not tolerate the exposure of the diseased surface to contact with the air without evident signs of distress.

To particularize more accurately the seat of the lesions: Beginning with the median line, it is seen that the continuity of the papillomatous surface is interrupted over the root of the nose by a small space of cicatricial tissue, from which the vegetations have cleared; above this break they fill the space between the eyebrows, terminating in a triangular prolongation in the median line of the forehead just above the superciliary

ridge. They spread over the right upper lid in a broad, continuous band, extending at the outer canthus of the eye quite to the edge of the lid, but separated by an interspace of healthy tissue from the patch over the right malar prominence. The left upper lid is occupied by isolated or aggregated lesions, extending in a linear series from the patch on the temple to the nasal border. The vegetations cover the entire nose, both alæ, filling up the naso-jugal and naso-labial furrows, and are continuous with similar outgrowths on the upper lip and either cheek. Upon the left ala there is seen a cleft or fissure, partly concealed by the overhanging, bossy excrescences, which when lifted up disclose an ovoid opening into the left nostril through the destroyed ala.

Upon the left temple the vegetations are continuous with those on the upper lid, extending over the side of the face to within an inch of the ear, the lateral lower border is circumscribed within a line drawn from the external auditory meatus to the left angle of the mouth, spreading over the upper lip, extending downward almost to the muco-cutaneous junction, and occupying three-fourths of the entire surface of the lip. The patch on the right cheek is more limited in area, its lower border being on a line drawn from the right external auditory meatus to the end of the nose, spreading out laterally over the right malar prominence. On both cheeks the vegetations advance to the extreme margin of the lower lids—which are inflamed and thickened, and everted, presenting an exaggerated picture of ectropion.

In addition to the papillomatous lesions, the patient exhibited a number of rounded protuberances in the right cervico-maxillary region extending in a vertical series from the lobe of the ear to the root of the neck. One was situated anterior to the angle of the jaw, the others along its posterior lateral border. They were several in number, varying in size from a hazel nut to that of an English walnut. They gradually increased in size along the descending line. They were soft and fluctuating, like gummy tumors just beginning to disintegrate. Over the apices of the tumors the integument was reddened, but unbroken and non-adherent.

Upon the forehead to the left of the median line, and partly within the margin of the hairy scalp, there is seen, partly concealed by the hair, a thin, smooth, non-adherent cicatrix, ovoid in shape, and 2 x 3 centimeters in area. Occupying a corresponding position on the right forehead, but entirely within the margin of the hairy scalp, there is an elongated cicatrix, scarcely discernible to the sight, but which can be felt as a slightly-raised band of cicatricial tissue.

Examination of the chest showed an absolute integrity of the pulmonary organs—appetite and general condition good.

On account of the patient's inability to speak English

and his extreme reticence, a knowledge of his history, and the origin and mode of development of the eruption could not be obtained. Although the papillomatous growths in this case did not correspond in many of their clinical features to the ordinary forms of the vegetating syphilide which develop from pustular or ulcerative lesions, they bore a certain resemblance



FIG. 1. After Julien.

to condylomata lata. The marked similarity of the vegetations to a case described by De Amicis as *frambæsioid condylomatous syphiloderm* will be seen by reference to the illustration (Fig. 1). As is well known, on account of the deceptive resemblance of frambœsia to certain forms of syphilitic vegetations, the former

disease was for a long time relegated to the domain of syphilis, but at the present day it is generally recognized as a disease sui generis and bearing no relation to syphilis. A diagnosis of syphiloderma frambœsioid was made, and the patient placed upon specific treatment. He was ordered pills of the protiodide internally, the crusts were softened and removed, the surface washed with dilute Labarraques solution, and covered with dressings of carbolized vaseline, changed twice a day. The pills of the iodide were soon discontinued, as they produced inappetence and slight pytalism. The following powder was ordered :

R    Acidi Salicylici..... grs. x.  
       Acidi Boracici..... grs. xx.  
       Calomel..... ʒi.

M.

The surface of the vegetations to be profusely sprinkled with it once or twice a day. Every second or third day the crusts to be soaked with a bread and milk poultice and removed. This treatment was continued with slight modifications up to May 1st, when my term of service expired. Under its influence the papillary outgrowths melted away, and several times seemed on the point of disappearance, but they soon sprouted up into quite as luxuriant a growth as before. From the left side of the nose they entirely cleared away, exposing to view an irregular ovoid opening in the left ala, sufficient in size to admit the point of the index finger, the size of the opening and integument over the nose was occupied by a somewhat sclerosed pigmented cicatrix. During this period the glands in the left side became engorged and somewhat painful. The tumor on the right cheek was incised and packed with iodoform two or three times, but it soon increased to its original proportions and became fluctuating. The patient now passed under the care of my successor, Dr. Bronson, and from the history book the following notes are obtained of the treatment during the next four months :

May 3d. Enlarged glands at angle of jaw reddened and fluctuating, so also smaller glands situated above them. Pills of the protoiodide were ordered and the crusts are softened with linseed oil and removed, and then a solution of bichloride of mercury (one part in ten parts of alcohol) was painted over the surface of the lesions. This treatment was continued for several weeks and was followed by relief of painful symptoms, and evidences of marked improvement in the condition of the lesions.

July 5th. An injection of three minims of the following solution were made into the patch at one spot.

R    Hydrarg Bichloridi..... gr. i.  
       Sodii Chloridi..... grs. v.  
       Mucilag. acaciæ.....  
       Aquæ..... āā. ʒ ss.

M.

July 9th. Daily injections of the above do not appear to have changed the lesions. Cloths wet with a bichloride solution (1-1000) were applied, and as they caused some irritation the strength of the sublimate was reduced to 1 in 2000.

August 1st. Above treatment was discontinued as patient was not improving. The solution of the bichloride was applied once a day, followed by a saturated solution of boracic acid.

August 16th. This does not seem to have done much good. Pure carbolic acid was applied to certain spots followed by crystals of boracic acid.

August 28th. Improvement manifest in some spots. To relieve the intense itching the following antipruritic oil was employed:

R    Liq Potassæ, .....  
       Acidi Carbolic. .... aa 3 iv.  
       Ol Lini Sem. .... 3 iv

M.

Upon my resumption of the service, September 5th, examination of the patient showed that while the papillary outgrowths were less exuberant over the right side of the nose, and had partially cleared away from the centre of the patch on the left cheek, yet there was a very evident extension of the area of tissue occupied. In the interciliary space the vegetations had advanced upon the forehead forming a quadrangular patch  $5\frac{1}{2}$  centimetres in length by  $3\frac{1}{2}$  centimetres in breadth. There had also been an extension upward over both temples and laterally on both sides of the face, extending on the left to within two centimetres of the external auditory meatus. The growth had extended downward upon the upper lip slightly overlapping the muco-cutaneous junction, and giving the lip an elongated appearance. When the lips are closed the vegetations show a downward curve like a mustache overhanging and partially concealing the opening of the mouth. Upon the lip the vegetations present a mammelated appearance. The nipple shaped prominences are distinct and separate, some of them form horny projections which rise like gigantic granulations one centimetre in height. The right ala of the nose is still covered and quite sclerotic. Upon lateral pressure the whole organ moves like a hard solid mass. Both upper eyelids are now completely covered from the eyebrows to the extreme conjunctival margin of the lids; they project downward over the eyeball completely concealing it from view. On account of the sclerotic condition of the lids they cannot be retracted either voluntarily or by force. The lower lids are forced forward and downward by the papil

lomatous growths, so that the conjunctival membrane formed a protruding almost horizontal floor.

The glandular tumors on both sides of the neck have entirely disappeared, the upper smaller ones leaving uneven whitish scars. The site of the one on the right cheek is occupied by cicatricial tissue in the form of a hard raised band, beneath which the point of the little finger may be inserted strikingly suggestive of a scrofulous scar.

During the four months' interim of my services, I was enabled to obtain a history of the beginning of the trouble, and certain phases of its development, and also was fortunate enough to secure a photograph of the patient, taken in May 1887, representing an advanced stage of the disease.

The patient was identified by his amputated arm, as a former inmate of the Hospital, and by reference to the Hospital Records a meagre history was obtained, the essential facts of which may be thus summarized:

Antonio L. was admitted to Charity Hospital, for the first time, November 10, 1885. On the 18th of July previous, while working on the railroad shoveling dirt, he felt cutting pains in his left wrist, which compelled him to leave off work. Upon resuming his work after a couple of days, the pain became so acute that he was unable to continue. At the same time he had a severe chill and fever lasting about eight days. The left wrist joint began to swell and get red. The joint continued to increase in size gradually, and twenty days after the onset certain red spots became raised above the surrounding surface, which finally broke and discharged quite a quantity of matter. The joint and hand continued to steadily get worse, and suppurate up to date of entrance.

*Condition on admission:* Patient thin and cathetic. Left wrist and metacarpal portion of hand much swollen, and showing three sinuses. These sinuses open respectively on anterior carpal region, at base of thumb, and at the carpo-metatarsal articulation on dorsal surface. The edges of the sinuses were surrounded by super-exuberant granulations, no necrosed bone detected by probing. Probe penetrates one of the sinuses three inches. A verrucose tubercle was observed on side of nose about the side of a pea, which the patient stated to be of nearly four months' standing. When subsequently interrogated upon this point, he stated that it appeared about a month after the spots on his hand. Without pursuing details of treatment which failed to relieve, the patient's forearm was amputated on December 4th, just above the wrist, the joint having been



diagnosed malignant. The stump healed slowly and during convalescence from the operation the tubercle on the nose continued to increase in size laterally, to become more verrucose, and to be covered with an ichorous, offensive discharge. Tubercles of similar nature appeared on forehead above left eye, and

FIG. 2.

three others on right side at margin of the hair. These lesions continued to grow until August 1, 1886, when patient was sent to Alms House. On the 31st of August the patient was transferred to Bellevue Hospital for treatment of stump.

From the history book of this Hospital the following notes are condensed. September 11th, upon opening up the sinuses the bone was found necrosed up to the articulating surfaces, the arm was amputated at elbow joint. The stump healed well; during October it was noted that the growth on the left cheek and nose was growing rapidly; it was diagnosticated epithelioma.

October 26th. Small mass of tumor removed from the left nostril which it was occluding, and base treated with actual cautery.

November 9th. Piece as large as twenty-five cent piece removed from nose, and base thoroughly cauterized, also left nares burned out.

December 6th. Patient transferred to Alms House. The lesions on face continued about same until December 1887, when they began to rapidly increase in size and extent.

The photograph of the patient, taken in May, 1887 (Fig. 2) represents a still more advanced phase of the development of the disease. It will be observed that the papillary excrescences occupy the entire surface of the nose, from the root to the tip, and have spread out on the left cheek over the malar prominence. A rounded or oval patch of vegetations is seen upon the left forehead a similar patch, more elongated, is seated upon the right forehead, but is concealed by the hair. These patches had entirely disappeared when the patient came under my observation ten months later, and evidently occupied the site of the cicatrices already described.

*(To be continued.)*

#### SOME POINTS IN THE DIFFERENTIAL DIAGNOSIS OF BLADDER AND KIDNEY AFFECTIONS (WITH A NEW INSTRUMENT).<sup>1</sup>

BY

ALEX. W. STEIN, M.D.,

Surgeon to Charity Hospital, Genito-Urinary Division, etc., etc.

OUR time is limited and the programme before us is so rich and gives so much promise, that I am admonished to be sparing of your time. The theme which, however, I have selected, admits of so vast an extension that I must content myself to touch lightly the most salient points, and leave the rest for your elaboration. In certain obscure ailments of the urinary tract the following questions not infrequently arise: Are the bladder symptoms due to renal disease? Are the kidney symptoms due to vesical disease? Are they independent of each other? And when one of the kidneys is involved

<sup>1</sup> Read at the Congress of American Physicians and Surgeons, September, 1888

which is the offending member? It has now become an axiom that the more remote pathological encroachments are from the vesical neck, the more tolerant is the viscus of their presence. Many instances might be cited to show the patience of the bladder, the tolerance of perhaps extensive structural change within its walls with scarcely a symptom to indicate disease. But, on the other hand, remote and often insignificant causes excite the organ to irritability, to an undue functional activity, this even in the absence of intrinsic alterations. Appreciating the fact that the neck of the bladder is the most sensitive part of the viscus, and that it is from this point that the afferent impulses originate which set into operation the co-ordinate movements necessary to bring about the physiological act of micturition, it is obvious that anything that will stimulate or irritate this portion of the organ, as the advent of pus into its cavity, which is as foreign to it as is a calculus, will augment this sensibility to an unnatural degree and produce the frequent and perhaps painful micturition. And again bearing in mind the intimate nervous connections which exist between the bladder and the neighboring pelvic organs, we can not be surprised that any disease or disturbance in the latter should arouse sympathetic action in the former, so that vesical irritability is excited not only by mechanical or contiguous irritation, but as often reflexly. Hence, we have availed ourselves of the dilatability of the female urethra for diagnostic purposes, as we have often made a perineal incision in the male for the same purpose, and while the electro-cystoscope has superseded in a great measure these operations I would *en passant* express my conviction, based upon mature experience, that in a large number of cases of vesical irritability in women, in which the exciting cause of the complaint is obscure, dilatation of the vesical neck affords prompt and signal relief. Having done what can be to correct any condition of system which may give rise to irritating urine without effect, and, I propose to make an examination of the parts, I almost invariably dilate the vesical neck at the same time; thus if I do not succeed in making a diagnosis, I am confident that my patient will obtain relief as the complaint is probably of neurotic origin. Even if it is not so, no harm is done, as I do not consider it ever necessary that the dilatation be sufficient to endanger the integrity of the sphincter. I rarely exceed five or five and a half centimetres, a degree of dilatation I have found entirely innocuous and satisfactory. But the dilatability of the

female urethra varies much. In some persons the meatus is rigid and very unyielding, while in others you can carry the expansion to the full capacity of my instrument, which is six and a half centimetres with scarcely any pain and very little delay. But I am not now called to speak upon treatment. I merely throw this in as not having received the attention it deserves.

How often have we accused the bladder of a disease of which it was innocent, simply because it expressed a source of irritation located elsewhere. How often have we mistaken the frequent micturition, pain referred to the neck of the bladder, and pus in the urine, the three cardinal symptoms, the tripod on which cystitis rests, as indicative of this disease and perhaps harassed the already overtaxed viscus with treatment, and at the autopsy (the logical outcome of the case) the bladder was found entirely healthy, but that one of the kidneys was converted into a sac of pus. The uropoëtic and genital viscera are so closely associated as regards their nerve influence that one part can not suffer long without affecting the remainder, and, therefore, it is that we observe severe pain in the bladder and testicles, without discovering anything to account for the same in the lower urinary tract, depending probably upon some nephritic malady, as calculus, hydro or pyonephritic accumulation, etc., and this applies not infrequently in the reverse direction from the lower urinary tract to the higher.

We naturally regard abnormal urine of renal origin, when it remains acid, is inoffensive and the pus retains its physical characters, and is not discharged in ropy masses, is disseminated equally and separates readily from the supernatant urine, especially when such urine is not passed with great frequency. A patient came under my observation just previous to my coming here, whose urine is loaded with pus, but who passes his water only about every five hours. I have examined him with the electric light, without discovering any abnormality in the mucous membrane of the bladder or in any part of the lower urinary channel. But, on the other hand, these physical properties of the urine in kidney disease, do not invariably correspond with our observation, for alkaline and stringy pus, often offensive, like that which ordinarily proceeds from the bladder may come from the pelvis of the kidney as the result of obstructive disease.

Then again urine that may undergo alkaline change in the pelvis of one kidney may be restored to its acid reaction by

admixture in the bladder with the product of the unaffected gland. In short, the physical characters of the pus, the reaction of the urine, the form of the epithelium, the presence or absence of albumen, are none of them unfailing tests, and have all disappointed time and again. Then, too, the appearance of filamentous shreds in the urine we were disposed to regard as confirming our suspicion of the existence of a vesical growth, but this, too, cannot be relied upon, as we learn from the interesting history given of a man who died in Guy's Hospital. He suffered with frequent and painful micturition, occasional hematuria, and passed with his urine small fragments of tissue. Nevertheless, at the autopsy there was found at the pelvis of the left kidney a sarcoma the size of the fist, from which the fragments were thrown off. But we are now, in most cases, enabled to draw a sharp diagnostic line between the diseases of the bladder and of the kidneys respectively by means of the electric light, and are now more frequently called upon to diagnose a unilateral or bilateral affection of the kidneys, when before we were engaged in the differential diagnosis between the diseases of the bladder and of the kidneys. There are still several conditions which interfere with a cystoscopic examination: First, A mechanical obstruction to the passage of the instrument, as in some forms of prostatic hypertrophy, or a strictured urethra; Second, Insufficient retentive power of the bladder for the injected fluid, as happens in certain cases of cystitis, in thickening of the vesical walls or an enfeebled sphincter power. These factors unfortunately frequently present. I have, at the present time, at least five or six cases under observation, in which they alone prevent such an examination. And, Third. In hematuria the injected fluid soon loses its transparency, so that we can see but indistinctly or not at all. I think this latter can be remedied by soldering an oval tube to the bottom of the cystoscope, which would reach to the curve, so that the bladder could be irrigated and refilled without removing the instrument.

The conditions being favorable for inspection, that is, the instrument can be introduced, and the fluid previously injected into the bladder is transparent; the presence of tumors, their size, number, mode and site of attachment, can be distinctly seen. The nature of foreign bodies can be made out, tubercular infiltration, ulceration, etc., seen. In short we can scarcely fail to obtain accurate data as to whether the vesical trouble is of a primary or secondary nature, and it further appears that a unilateral diagnosis of diseased kidney has been revealed by ob-

serving from which of the ureteral orifices a hematuria or pyuria has its source, for these orifices are distinctly visible. In cases in which we can eliminate the bladder from the causation of the complaint, and have reason to believe that the morbid products in the urine are derived from the urinary tract above the bladder, the question comes up, which of the kidneys is at fault? The difficulty of making a unilateral diagnosis of renal disease before it has advanced to a degree calling for the extirpation of the kidney is known to all surgeons, and when it comes to the question of a nephrectomy much depends upon determining the functional activity, not alone of the offending member, but of the opposite organ that will be called upon to do double duty in the event of an operation. That in time one kidney will gradually assume the duties of both, was again strikingly illustrated in the case of a prominent politician of New York, who died after four days only of illness. He had ever been an active man, and his demise was altogether unexpected by his friends. He never complained of his uropoëtic viscera, and yet, at the autopsy one kidney was found converted into a translucent sac. Every vestige of excreting structure was destroyed. The ureter, for half its length, was converted into an almost impermeable cord, through which a probe could not be made to pass. This was no doubt at the root of the mischief, but what caused the obstruction the gentlemen who were present at the autopsy could not make out. There was no evidence of tubercular infiltration or of calculus found anywhere, and there was no inflammation and suppuration in the sac (an immunity rarely met with in calculus obstruction) or other evidence of antecedent disease observable. The cyst was smaller in its diameter than a kidney usually is, and therefore we have reason to affirm that the atrophy occurred very gradually, and not by a sudden dilatation of the pelvis of the kidney. This organ was absolutely useless, it was practically non-existent, and had been so doubtless a very long time. The other kidney had undergone a compensating hypertrophy, and maintained the needs of the economy until it became incapacitated by taking on a lardaceous change, suppression of urine supervened, and he died at last with uræmic symptoms. As far as my experience goes, so extensive a destruction of an important organ rarely pursues so insidious a course, and the outcome of the patient is exceptional, with unimpaired physical health and without the usual outward expression of irritable bladder, of which he did not complain.

It is a nice question to decide, whether the patient can afford to do without a diseased viscus, however imperfect its eliminating action may be, and we have to be on our guard not to remove a diseased kidney and leave a long-since atrophied organ behind, or that we do not extirpate a partially atrophied but otherwise inoffensive viscus, and leave a suppurating gland behind. For these mistakes faulty diagnosis has been responsible for more than once. But renal surgery is becoming daily more exact, and grave mistakes in diagnosis are to-day comparatively infrequent, especially since we have learned that digital exploration of the pelvis and calices of the kidney through a lumbar incision should always be the primary operation.

As nephrotomy does not diminish the functional activity of the kidney (unless it does so by suddenly removing pressure from an over-distended pelvis when suppression is likely to ensue), the mortality after the lumbar operation depends, as Mr. Morris suggests, rather upon the condition of the kidneys, for which the operation is undertaken, than upon the operation itself. It exposes the patient, in perhaps a majority of instances, to the discomforts of a urinary fistula, but it gives temporary if not permanent relief, by affording ready exit to calculus, to pent-up urine pus, etc., and it may also be incidentally said that a secondary nephrectomy is often successful when a primary would not be. Then it has an additional advantage in that, in diverting the urine from the morbid viscus we are enabled to determine the working power of the opposite kidney, and, according to its efficiency or deficiency, be governed as to the feasibilities of a secondary nephrectomy.

A variety of novel and fascinating procedures and instruments have been devised and employed, with the view of determining the exact condition of the right or the left kidney with reference to its excreting power, plus any abnormal ingredient which the urine may hold. Some of these methods are "uniformly successful" we are informed, but are we not too apt to run to extravagant statements when a new idea strikes us as feasible? Before our enthusiasm has had time to cool we give expression to our sanguine hopes in language which should only be the outcome of a ripe experience. If these methods are uniformly successful and "nothing more is desired," it is beyond comprehension that such grave mistakes should have been made in renal surgery by men who are keenly alive to every important innovation in diagnosis.

The first of these is catheterization of the ureters, this method

consists in that after dilatation of the urethra in the female, a finger is introduced into the bladder, and guided by the latter, a fine catheter is passed into the opening of the ureter. When the ureter is from some cause dilated, this procedure may be successful enough, but when this is not the case it requires, it seems to me, no less than the *tactus eruditus* of Simon<sup>1</sup> who says he rarely fails in entering the ureteral orifice. The difficulties attending this procedure have but to be tried to be appreciated. It has been proposed to effect the same result, during the illumination of the bladder with the electric light, but I think the manipulation of the catheter is too much interfered with by the presence of the cystoscope to be available. Those who have not been so fortunate after repeated and persevering trials, propose to catheterize the ureters through an incision in the vesico-vaginal septum, and even this has proved unsatisfactory, if we are to infer from the suggestion of Hegar,<sup>2</sup> who proposes to lay bare the ureters, through an incision of the anterior vaginal wall, and ligate them alternately. Lewers<sup>3</sup> dilates the urethra and then passes a Bryant's rectal speculum, so that it occupies one side of the urethra and bladder, and the character of the urine escaping from the other ureter is observed and examined. The speculum is now quickly turned to the other side, thus bringing the other ureter into view. In a case in which he employed this method he says "a little fountain of clear urine about a quarter of an inch high escaped from the right ureter, the exit from it having been prevented by pressure of the speculum while the left ureter was being observed."

Iversen<sup>4</sup> recommends and has practiced with a very satisfactory result, catheterization of both ureters, after an exploratory supra-pubic incision into the bladder. He found an almost clear urine flowing intermittently from the right ureter (the natural character of the flow), while from the left ureter there was a continuous flow of a purulent fluid. While the left kidney thus showed active pathological change, he nevertheless did not venture upon a nephrectomy, because of the evidence of the existence of disease, in the advent of innumerable epithelial elements, a few red corpuscles and not a few hyaline and granular casts from the opposite side. Silbermann<sup>5</sup> tries to compress the ureteral orifice by means of a bag of metallic mercury.

<sup>1</sup> Simon Sammlung *Klin. Vorträge* No. 33, 1883.

<sup>2</sup> Hegar *Operativen Gynakol.* 5, 456.

<sup>3</sup> Lewers' *Lon. Lancet*, November 13, 1886.

<sup>4</sup> Iversen *Centralb. f. Chirurg.* No. 16, 1888.

<sup>5</sup> Silbermann *Berl. Klin. Woch.* No. 34, 1883.



He introduces a catheter at the fenestra of which is a rubber balloon, covered during the introduction of the instrument by a slide. It is guided in position by the finger in the vagina or rectum, the fenestra is opened and the balloon distended by means of a syringe with mercury to the size of a goose's egg. Tuchmann<sup>1</sup> has devised an instrument which he calls a ureter forceps. It is in shape like a lithotrite and has two long slits to allow the urine to flow from the bladder. It is designed, when introduced into the empty bladder, to clamp or grasp the orifice of one of the ureters and thus allow only the urine to flow from the other. He says the manipulation of the instrument does not require any special dexterity, but although I have followed his directions implicitly, am free to confess I have thus far not found it so easy.

I have thus very briefly collated some of the various methods known to me that have been employed to secure the ureters for purposes of diagnosis, and from these diverse operations the inference is, I think, unavoidable, that we have not



yet attained the means for the end. I, too, have devised an instrument, with a brief description of which I shall close. It must stand on such merits as it may present to you. It is just completed, and I have not had the opportunity of putting it to the crucial test, that is, on a suitable patient. It consists of a metal catheter 30 F. The curve of the beak is just sufficient to lie snugly against the trigonum, and when deflected towards the right or the left ureter comes directly over the orifices of these ducts. As the mouths of the ureters are about an inch from the vesical orifice, and about half an inch on either side of the median line, the instrument has only to be introduced into the bladder one and a half inches, there being an additional eye two centimetres from the tip of the instrument on its convex surface, *a*, to indicate when the bladder is reached by the flow of urine. The situation of the catheter may be further accurately deter-

\* Tuchmann *Harnleiterpincette* Berlin, 1887.

mined by the finger in the vagina or in the rectum. Within the catheter is a straight, hollow tube, 12 mm. in calibre, to which is attached at the distal end a rubber cap which is concealed when the instrument is being introduced. When in position, opposite the orifice of the ureter, the rubber cap previously lubricated, is pushed out, when it presents an open mouth nearly six centimeters in circumference, *c*. Aspiration, *f*, is now effected, and the orifice of the ureters is forcibly sucked up by the rubber cap, and the contents thereof becomes, after some few moments, apparent in the glass, *e*, that is attached to the proximal end of the catheter.

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#### A CASE OF HEREDITARY SYPHILIS SIMULATING LEPROSY.

BY

A. H. OHMANN-DUMESNIL, A.M., M.D.,

WITHOUT desiring to make any apology for the following short clinical report, it may not be altogether out of place to preface it by a few general remarks. That cases similar to the one I am about to describe are unusual, a glance at the literature of syphilis will indicate. That the present case is one sufficiently important to call attention to the increasing number of cases of leprosy found in this country, would seem to indicate. This is the more important since those unfortunates, afflicted with the latter disease, are isolated and removed from all association with friends and relatives. On this account alone a most thorough diagnosis is absolutely necessary, and the following case is reported; also, because it had been diagnosed and treated as one of lepra.

*Case.*—Chas. T.—was first seen by me in 1886. He was about 18 years of age at the time. Inquiry into his history elicited a number of facts which, together, with a personal examination, established a tolerably certain diagnosis. His father, twenty-five years previously contracted syphilis, and had been to Europe for treatment. He is still living, and has an ulcer of the leg of very suspicious appearance, as I learned from his attending physician, who was the one to present Chas. T.—to my notice, in order to obtain a diagnosis. Otherwise the father apparently enjoys a fair degree of health. Of the mother, little or nothing of any value could be learned.

Up to the age of fifteen, the patient had apparently not exhibited any symptoms which would lead his parents to suspect that he had any general disease. They had not noticed any

eruption. At this time, however, an ulcer appeared on one of his legs. His physician informed me that his skin began to get scaly, and that he was informed by an oculist that there existed the remains of an interstitial keratitis. His hair fell out, he lost the nasal bones, and his palate became affected in the process.

When I saw him he presented the appearance shown in the annexed engraving. There existed a general tubercular infiltration of the face and ears; the bridge of the nose had disappeared; the organ itself, having flattened more or less, was broad at its base, and he had well marked ridges in the face.

The lobes of the ears were considerably thickened and enlarged, as well as the conchæ. The hands also exhibited the same general characteristics. On the body, the remains of a few ulcers were plainly to be seen. The hair, light in color, was scanty. Voice high-pitched, and not very distinct in articulation. The skin was more or less velvety to the touch, and apparently hypertrophied, it was very thick, and yet it had more or less of an elastic feel. The secretory functions of the skin were impaired, and in some places absent. Nervous sensibility was normal, and no nerves enlarged. Ganglia somewhat enlarged, but not painful.

As can be seen from the engraving, upon first looking at him, one would naturally suspect leprosy, and his disease was so diagnosticated by a physician who administered large doses of chaulmoogra oil with no benefit, but rather the contrary.

The patient was sent to Hot Springs, Ark., and apparently experienced some benefit. The plan of treatment which was followed in his case was about as follows, as given me by his attending physician, who has had him under treatment for about two years, and under which he has improved to quite a marked degree:

Iodide of potassium was given in gradually ascending doses, from ten grains to two drachms, three times a day. After a time this was discontinued and he was placed on the Pill Burdo Co. (Marks'), which may be described as follows:

Each pill weighs  $5\frac{1}{4}$  grains and is composed of the following: ext. Berberis aquifolium, ext. rumex crispus. ext. cascara sagrada, ext. similax officinalis, ext. lappa minor, ext. trifolium pratense; res. stillingia, res. phytolacca, res. xant oxylum. He was given one pill thrice daily for some considerable time, but as the improvement did not seem to be what was desired, 1-8 grain of proto iodide of mercury was added to each pill, (Pill Burdo Co. cum, hydrarg.) and given thrice daily. Under this medication, good results soon manifested themselves, and when last seen by me, the patient seemed in a fair way to recovery.

Very few external applications have been made in the case. Whilst being treated for leprosy, chaulmoogra oil was applied externally for a time, and afterwards discontinued. At Hot Springs some mercurial applications were made, and under his last treatment he has been annointed on the face and hands with a mixture of a drachm of salicylic acid to the ounce of lanoline,

and this has, in a great measure, tended to reduce the thickness of the skin.

It has been impossible to obtain another photograph of the case, as it stands at present. The patient is an individual whose mental faculties are not of a high order. He is very obstinate about showing himself, and positively refuses to sit for a photograph, and, latterly, has been evincing a dislike to speak of his condition. There is, however, but little hope that his face will ever return to a normal condition. His skin is much thinner, but there is some deposit which seems to bear the marks of a permanent nature.

ST. LOUIS, MO..

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## Correspondence.

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### DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

#### The Transmissibility of Leprosy from a Leper to a Healthy Person.

The recent discussion at the Academy of Medicine of Paris on Leprosy is, indisputably, the dermatological question which has most occupied the minds of medical men in France since my last letter. The believers in the microbic origin and transmissible nature of this affection had to again contend with eminent men who will not recognize in this disease the characteristics of a malady directly or indirectly transmissible from an affected person to one who is healthy. As this is a question of the day, and a subject full of interest for dermatologists of the United States, I beg permission to give a complete yet succinct account of the state of the question in my own country.

#### Account of Work Anterior to Present Academic Discussion.

It is not to be supposed that we have only now begun to dread leprosy. In 1881 my eminent teacher, Dr. E. Vidal, in a series of lectures which I had the honor of publishing, declared that in view of the epidemic in the Sandwich Islands and of the discovery of bacilli by Hansen, he could no longer deny the contagious nature of leprosy. But it must be acknowledged that at that period this was an isolated opinion. Counting Dr. E. Besnier and myself, there were perhaps but three in France who took this view of the question.

In 1885, apropos of a work of Dr. Zambuco on leprosy at Constantinople, Drs. Constantin Paul, Desjardin-Baumetz, Hardy and LeRoy de Mericourt maintained before the Academy of Medicine of Paris that the disease was in no way transmissible from an affected person to one in health. Dr. Vidal was alone in the contest, and it was in vain that he brought forward arguments of the greatest value in support of his opinion; the scientific assembly before which he spoke gave no consideration to the proofs which he presented, in fact scarcely consented to hear him.

We therefore thought it necessary to combat this tendency, and we treated the subject thoroughly, from a clinical point of view; in papers which

appeared in November and December, 1885, in the *Annales de Dermatologie et de Syphiligraphie*, I determined to set aside all theory and to study nothing but facts. After having proved that leprosy is a malady of slow growth and chronic, which takes much time in developing, it must be, consequently, difficult to find the direct and evident proofs, I might say even indications of the contagion. I proved that in such a question one cannot be led astray by the mass of negative facts which are presented by the anticontagionists. Negative facts in reality, it matters not how numerous they may be, can prove but one thing—that leprosy is not inevitably contagious; that many persons are not apt to contract it. By their multiplicity those negative facts prove that, in certain countries and under certain conditions, as yet but vaguely known, leprosy is but slightly contagious. But, indeed, they do not prove (and I am still of the same opinion were they hundreds or thousands more numerous) that leprosy is never transmissible from a leper to a person in health. If there really exists one fact—one positive, well observed, well established fact—of the transmissibility of leprosy from an affected person to a healthy one, the proof of the transmissibility of the disease would be established despite all the negative facts which could be gathered.

Now those proofs existed already, 1885, and in my work I group them into four principal categories, to which I shall return further on and for the present be content to enumerate.

*First, Isolated facts of Contagion. Second, Slight isolated epidemics. Third, Recent great insular epidemics. Fourth, Evolution of great epidemics of leprosy.* I concluded my paper by showing that the arguments of the anticontagionists were most easily refuted, and that after a careful study one could not accord them the least value. The efforts of Dr. Vidal, together with my own, finally brought about a certain reaction. In 1886 appeared the superb treatise on leprosy by Prof. Leloir de Lille, in which after some previous hesitation, this learned dermatologist declared himself a partisan of our opinion, and even did me the honor of reproducing my work in *extenso*.

Finally, on October 11, 1887, my eminent teacher, Dr. E. Besnier, read at the Academy of Medicine of Paris a most remarkable paper, which is the most complete, concise and clear argument which has ever been delivered in favor of the doctrine which we support. After having proved the parasitical and microbic nature of the disease and having studied the localization of the bacilli of Hansen in the liquids and solids of the organism, this author examines the origin and the modes of propagation of the affection. Leprosy is evidently caused by a bacillus. Now the question resolves itself into this: Where does the bacillus come from?

The exterior origin and the indirect transmission of leprosy have as yet been but insufficiently studied. On the other hand numerous irrefutable documents show clinically, if not experimentally, that leprosy is directly transmissible from the leper to a healthy person. After studying the question of hereditary transmission of leprosy or hereditary leprosy, Dr. E. Besnier demonstrated that this doctrine, which is accepted by the majority of medical men in its general sense rests, in reality upon facts, not very convincing and much less numerous than would at first sight appear.

After reading this important paper we thought that in France, the question in discussion was definitely settled in the affirmative. That this, nevertheless, was not the case has been proved by the discussion which has just taken place at the Academy of Medicine of Paris.

### Discussion of 1888 at the Academy of Medicine.

It was May 15, 1888, that Dr. LeRoy de Mericourt answered Dr. Besnier's paper of which we have been speaking.

In a very lengthy communication he heaped document upon document, and argument upon argument to prove that numbers of individuals live in daily contact with lepers without contracting leprosy, and that the almost unanimous conviction of observers is that leprosy is not contagious. He also protests most vehemently against restrictive measures being taken in regard to lepers. And strange to say this communication which, from its lack of clearness and precision escapes analysis, was favorably received by the Academy of Medicine, indeed, was warmly applauded.

Happily other members of this distinguished assembly came forward and took up the discussion. Professor Leloir (de Lille), correspondent of the Academy, reproduced on May 29, 1888, to a great extent that which he had already written in his book, and proved that although the inoculability of leprosy has not as yet been demonstrated, the propagation and increase of this malady cannot be accounted for except by contagion, or in part heredity. There is, another question, nevertheless, whether leprosy is contagious on the outset from individual to individual; in a word, whether the bacillus of leprosy can pass directly from a diseased subject to one that is healthy and contaminate the latter, or whether, on the contrary, it is contagious in a secondary way only, that is to say whether the bacillus undergoes, before its transmission to a healthy subject, an intermediate development in a centre which is unknown to us. In any case, as he distinctly says, this can never be but a detail; whether leprosy be contagious in the beginning or secondarily it is none the less a contagious disease. Dr. Leloir concludes his paper by showing the good effects of isolation in those places in which it is practiced, particularly in Norway, and in asserting in contradiction to Dr. LeRoy de Mericourt that numbers of physicians living in leprosy countries are contagionists or show a growing tendency to become such.

It was in the same strain that Dr. E. Vidal spoke on the 19th of June. After recalling the fact that in 1885 his support was so meagre in numbers that he looked upon himself as almost the only French contagionist, our eminent teacher shows the progress which his doctrine has already made in France and in a clear statement he groups the proof of the transmissibility of leprosy into three great classes.

*First, proofs deduced from the paractical nature of leprosy, which at this period should be considered as perfectly established; Second, proof drawn from the existence of well proven or acknowledged cases of transmission of leprosy from a leper to a healthy subject. Third, proofs drawn from the advance of epidemics of leprosy and the possibility of stopping them by active prophylactic measures.*

At the same meeting Professor Cornil in a most interesting communication shows that as yet very little is known about the bacillus of leprosy; one cannot, therefore, at this period, make use of its existence to prove in a mathematical manner the contagiousness of this affection or to batter it in the breach on account of the negative results given by the culture and inoculation of this bacillus, but, he says, in the absence of experimental pathology there remains the clinical observation of lepers, and he finished his paper by relating several cases of leprosy contagion which one excellent colleague and friend, Dr. Chanterness, has gathered in France, on the coast of the

Mediterranean. He concludes by saying that "one sees occasionally a leper or an immigration of lepers become the centre, around which are established homes of lepers." Dr. LeRoy de Mericourt himself admits that the cohabitation of a healthy woman with a man who is infected, or the reverse, may generate leprosy in the one who up to that time had been healthy." These are undeniable facts in favor of contagion, but our knowledge relative to the biology of the bacillus of leprosy is as yet too limited to give a complete and scientific explanation of it.

Again, one might have supposed that this question was definitely settled; not so. On June 26th we saw to our great surprise our dear and venerated Dean of French dermatologists, Professor Hardy, come forward and declare that he does not believe that the question of contagiousness or non-contagiousness of leprosy can at this period be determined in a definite manner. According to him it will remain thus unsettled so long as no positive results from the inoculation of the disease are obtained. The propagation of leprosy seems to him to be a matter of race and climate.

The temperate parts of Europe offer complete indemnity, so to speak, from the disease; he sees no necessity for taking any prophylactic measures.

Such is, very briefly summed up, the whole of this important discussion; but it seems to me necessary, in order to give a clear idea of the actual state of this question, to now group in a didactic manner all the arguments used by the French contagionists, of whose number I have the honor of being one, and those of our adversaries. I shall confine myself to giving merely a brief outline, but one which will enable those who wish to study this important question to become immediately acquainted with it.

### **Proofs in Favor of the Transmissibility of Leprosy from Lepers to Healthy Subjects.**

*I. Theoretic Proofs.*—Leprosy is a microbic disease; the bacillus is the cause, the source of the affection; hence it is transmissible directly or indirectly from a leper to a healthy subject who is predisposed to it, and who is in the condition requisite to its reception.

*II. Experimental Proofs.*—Although it has been maintained that all the inoculations of leprosy up to the present day have been negative, there exists, nevertheless, known cases of leprosy in which the transmission of the disease has been attributed to vaccination. One of the most convincing is that of Dr. Gardener (*British Medical Journal*, June 11, 1877). Dr. X., who was practicing in the tropics, was so imprudent as to vaccinate his own child with virus taken from a child issue of a leprosy family, in whom (but this has not been ascertained in a definite manner) leprosy afterwards appeared; then taking the virus from his own child, vaccinated a second one. Both children became lepers.

*III. Clinical Proofs.*—Those proofs, which become more and more numerous as the attention of medical men is attracted to the subject, may be divided into four principal groups.

#### **Isolated Cases of Contagion.**

We have classed them into three categories.

*a. Cases in which individuals who are the issue of healthy parents, never having lived in countries in which leprosy is endemic, have been infected after having had intimate relations with lepers.*—Those cases, to our



minds, are unquestionable; they constitute irrefutable proofs of the opinion we defend. Such is the celebrated case of Dr. J. Hawtrey Benson (*Dublin Journal Medical Sciences*, pp. 562, June, 1887) which we may state in the following manner: An Irishman lives twenty-two years in India; he there contracts leprosy and returns to Ireland with all the exterior attributes of the affliction. He enters Dublin Hospital, and, during his sojourn there Dr. Benson presents him in his service to the Medical Society of Dublin. He afterwards returned to his home, and there, at the expiration of a year and a half, he died. During this last period his brother slept in the same bed with him and wore his clothes. This brother had never left Ireland except on one occasion, forty-six years previous to this date, when he spent some time in England. After this fraternal cohabitation he contracted leprosy, and for greater certainty Dr. J. Hawtrey Benson brought him also before the Medical Society of Dublin. There had been no other leprosy antecedent in the family. One could not then doubt that he had been contaminated by his brother. This observation, it seems to us, furnishes an incontestable case of transmission of leprosy from a leper to the healthy subject. We do not see what objection could be brought against it. No typical case could be invented for the demonstration of our opinion which could be more precise and complete than the one above stated. (Then, again, is the case of Dr. Atkinson.) (*Archives of American Medicine*, June, 1882).

*b. Cases in which individuals, issues of healthy parents, but living in countries where leprosy exists, have become lepers after having intimate relations with lepers.*—Those cases multiply; we will relate, among others best known, those of Drs. Vidal, Poupinel, Costales, Vallin, Goldschmidt, Drögnat, Landré, etc., etc.

*c. Cases in which individuals, issue of healthy parents, have become leprosy after having lived for some time in a country in which leprosy is endemic, and after having been exposed to the contagion.*—Those two latter groups are open to an objection which the anticontagionists do not fail to formulate. Since the subjects have become diseased in a country in which leprosy prevails, how can it be known that their leprosy has its origin in contagion, or in the other causes, mysterious, it is true, which are brought forward by certain physicians as the etiology of the affection? Let it suffice for me to recall here the fact that apart from heredity and contagion we know nothing definite concerning the origin of leprosy.

#### Second—Slight Isolated Epidemics.

When a malady is contagious, and an individual who is attacked with it and placed in a centre which up to then had been healthy, creates about himself a home of infection, it is the study of those little, partial epidemics, when they can be observed in various localities, which best enables one to specify the mode of propagation and the degree of transmissibility of the disease. The possibility of a contaminated subject thus developing a home of infection in the centre of a primitively healthy population, constitutes the very characteristic of contagious affections. Now, those little epidemics have already been observed in leprosy. They are to be seen at this very moment. New ones are constantly discovered. Need I recall the two epidemics of Cape Breton and of Louisiana, which are ably described by Dr. White in his memoirs? I might cite in addition the epidemics of Turbie, Trinity, Laghet and others on the Mediterranean coast of France

(see Professor Cornil's communication to the Academy) ; that of Parcent, in the Province of Alicante (see *Annales de Dermatol. et de Syph.*, June, 1888).

### Third—Grand Insular Epidemics.

You know too well the history of the recent great epidemic in the Sandwich Islands for me to more than mention it. I will merely add that in the last century there occurred in Maurice Island that which in our day happened in the Sandwich Islands.

### Fourth—Evolution of great Epidemics of Leprosy.

Leprosy has always moved itself according to human current. It has always developed in the midst of heedless, careless populations and, on the contrary, it has always died out when vigorous hygienic measures have been adopted, or leprosy subjects isolated. Those fluctuations, according to the laws which we have just mentioned, have constantly taken place in the middle ages, as well as in our day. We see leprosy increase in Madagascar, in Spain, on the coast of the Mediterranean, and in Russia, where no restrictive measures are taken, whereas, it decreases in Norway since the isolation of lepers has been prescribed; this diminution is in direct proportion to the rigor of isolation. Such are in their ensemble our arguments, those of the French contagionists. Never up to this time have they been seriously attacked.

## ARGUMENTS OF THE ANTICONTAGIONISTS; THEIR REFUTATION.

### I. Leprosy must Acknowledge Causes Other than Contagion.

*First, There exists cases of sporadic leprosy.*—Attention has, indeed, been called to some cases but they are rare, in which leprosy has appeared in subjects, issues of healthy parents, inhabiting uncontaminated countries, which they have never left and who never had had the slightest contact with a leper. But the real existence of those cases is far from being proved, they have never been submitted to serious criticism; moreover, what difficulties does not such an inquiry present. Since it is known that the inoculation, or if you choose, the latent period of leprosy may last during years. Besides, the real existence of such facts could in no way destroy the positive proofs that exist of contagion.

*Second, Leprosy is above all a question of race and climate. The most efficacious means for those who live in leprosy countries of arresting the encroachments of the disease is, if they have the means to do so, to emigrate to some large European city.*—This argument, already formulated by Dr. LeRoy de Mericourt' was most ably supported by Professor Hardy (discussion of June 26, 1888, Academy of Medicine, Paris). We long since refuted this objection and showed that leprosy exists in Norway as well as in Constantinople, in Africa as well as in Hindoostan, in Brazil as on the western shore of the Mediterranean, among the white, yellow and black men. In a word, it is the leper who creates leprosy countries and leprosy races. We, moreover, in no way deny the predispositions to the affection, more or less great, which are the results of climate, hygiene, surroundings, etc.

*Third, Leprosy has for origin heredity alone and not contagion.*—Indeed, this seems to be the result of a very imperfect first examination of facts. But at this period words do not satisfy; and in going to the bottom of things it is

seen that heredity in leprosy cannot be regarded as heredity in its ancient acceptation nor a defect in the protoplasm, but a complete transmission to offspring of a specific element, introduced by the seminal passages, or more directly by the utero-placental circulation. It is, therefore, contagious, but in a special way. Moreover, heredity is by no means to be met with in all lepers born in leprous countries; there exist cases in which parents have become diseased after the children. The children of a leprous man or of a leprous woman are not always afflicted with the disease. There are, as in the Sandwich Islands, epidemics of leprosy, the spread of which has been so rapid that heredity does not suffice to explain the genesis of all the cases.

## II. Negative Facts.

*The anticontagionists tell us that there exists an enormous number of negative facts proving that leprosy is neither inoculable nor contagious.*

Those facts exist; we are the first to acknowledge and proclaim it. They may be grouped in the following manner:

*First, It has never been possible to transmit leprosy to animals.*—It has never been possible to inoculate them with syphilis. Is this not, nevertheless, a disease eminently transmissible from man to man?

*Second, The inoculations made on man have not taken.*—We might reply that, so far, nothing is known of them, and that probably the conditions necessary to the success of those inoculations are unknown. Syphilis, at the end of some years may kill, and yet its lesions are not inoculable. But the examples of vaccinal leprosy which exist tend to show the reality of the direct inoculability of leprosy.

*Third, Man and wife often live many years together, and even have children, without the leprous husband infecting the wife.*—Those cases exist, but, on the other hand, the cases of marital contagion are already so numerous that they constitute one of the most powerful arguments which are held in favor of the transmissibility of leprosy from leper to a healthy subject.

*Fourth, Physicians, attendants, etc., do not take leprosy from patients in their care.*—This argument is open to the same objections as the preceding ones. I cannot really understand using the immunity of physicians as an argument against the transmissibility of the disease. Do we not handle syphilis daily in the hospitals under our charge and, notwithstanding this, the cases of medical transmission of this disease might be counted.

We escape it, although it is, certainly, much more easily inoculated than leprosy, by taking certain care of ourselves, by giving attention to hygiene and cleanliness. How can it be claimed that those precautions would not prove more efficacious in an affection (leprosy) which, according to all, is diffusible in a much less degree.

*Fifth, Lepers coming to Paris into the midst of a large population, to the Hôpital St. Louis in particular, have never transmitted the disease nor created seats of leprosy.*—This argument is open to the same objections as the preceding ones. Is it known whether those cases of so called sporadic leprosy, of which so much has been said, are of this origin? It is not in hospitals nor in the midst of populations which have reached a high degree of cultivation and hygiene that one should expect to see lepers create homes or centres of leprosy; the precautions taken in regard to them are too great. Study them when they arrive on a virgin soil, in the midst of an ignorant

backward population, you will then see developing around them seats of leprosy. Such as in the Baltic provinces of Russia, on the Mediterranean coast, in France and in Spain, etc.

### III. The Facts Published in Favor of Contagion are Inexact.

This objection is not worthy of refutation. We will content ourselves with calling attention to the fact, that the anticontagionists have never dared to openly approach a discussion of the positive facts which we have to set forward.

### IV. The Contagionists do not Agree among Themselves, and Quite Frequently Contagion Cannot be Found to be the Origin of Disease in the Leper.

To acknowledge that leprosy may be transmitted from a diseased subject to a healthy one, is it necessary to prove that every stated case of leprosy had its origin in the direct inoculation of a leprosy product, or in the prolonged cohabitation with a leper? Must it be proved that all direct inoculations of a leprosy product that all prolonged cohabitation with a leper gives leprosy? It is simply absurd, it is denying all possibility of immunity for leprosy, it is ignoring the long incubation of the disease and the difficulties of studying its first periods. If the contagionists have among them any points of difference they are but of detail. They do not yet know how the transmission of leprosy takes place; this important point calls for a long and patient research. Some think that leprosy is directly inoculable, others think the virus requires intermediate culture in order to develop in a healthy person, others that leprosy virus is inoculable only at certain periods of the evolution of the disease; but all agree on the main primordial point, that there are clinical, positive, incontestable facts which prove that leprosy is transmissible from affected person to a healthy subject.

### V. Physicians of Countries in which Leprosy Prevails do not Believe it to be Contagious.

It is useless to point out how little value there is in this argument. If there are physicians practicing in leprosy countries who do not think the affection contagious, there are others quite as numerous if not more so, for instance, the Norwegians, the Hawaiians, the Spaniards, etc., who maintain the opposite idea and bring to the support of their opinion irrefutable proofs.

Such is summed up in a few words, the present state of the question in France. It is seen, we are firm contagionists, and we hope in a time to come, that those ideas, conformable to clinical observation and scientific medicine, may meet with no opponents in the medical world.

PARIS August, 1888.

DR. L. BROcq.

## London Correspondence.

*To the Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES:*

DEAR DOCTOR—Perhaps some notes upon dermatological matters in this city, may be of interest to the readers of your valuable Journal. Of late there have appeared not a few letters, from more or less distinguished

Englishmen, telling their countrymen how we live, move and have our being, and some of these have not been very flattering to us. I would write in no critical spirit, nor attempt to describe the manners and customs of the English people, after only a brief sojourn. My only object is to jot down a few brief gossip notes upon some phases of medical life here, hoping that they may serve to brighten a few moments for some of your readers, and mayhap be of use to some who contemplate coming here to study.

London is a vast beehive, numbering amongst its workers some four thousand medical men, some of whom are called doctors, some surgeons, some apothecaries. The surgeons are grieved if you call them "doctor;" "mister" is their title. The doctors are of course, called "doctor." This stickling for titles is somewhat confusing, and a source of embarrassment at times. Our way of calling all "doctors," is more convenient. The proper form of address in writing is "John Smith Esq." for the surgeons; "Tom Brown Esq., M.D." for the doctors. But here again we run against a snag, for some of the doctors are only bachelors of medicine, and such must be addressed as "Robt. Jones Esq., M.B." Use accustoms one to all things, and perhaps to one who has acquired a knowledge of the distinctions between Earls, Dukes, Marquises, Lords, Barons, and so on infinitum from earliest infancy, such nice points come easier than to one of us. Now, some of the dermatologists here are surgeons, and some physicians, and hence these remarks. This shows that our beloved specialty has not yet attained to its settled place, but occupies a position similar to that of syphilis, which is claimed by both the venerealist and the dermatologist. However, these little niceties of language are but trifles, and the London medical men are like their fellows everywhere, a very pleasant set of men. Of course an introduction to a few of them will be useful to any one coming here, but I am quite sure that any decent fellow will be pleasantly received by them, if he simply presents his card and says that he is from America.

London is as great in its charities as in its fashion, and has many hospitals, among which are four, I believe, which are specially for skin diseases. Skin patients are received in nearly all, if not all, of the general hospitals, and most of them have dermatologists in attendance. Thus we find Mister Wm. Anderson at St. Thomas Hospital; Dr. Cavafy at St. George's; Mr. Cripps, at Bartholomew's, Dr. Duffin, at King's College; Dr. T. Colcott Fox, at Westminster; Dr. Mackenzie, at the London; Mr. Morris, at St. Mary's; Dr. Perry, at Guy's; Dr. Pringle, at Middlesex and Dr. Sangster, at Charing Cross.

Of those hospitals which are specially for skin diseases, the leading one is Blackfriars, as it is generally called though its proper title is "The Hospital for Diseases of the Skin." This is located at 52 Stamford Street on the Surrey side of the Thames, and readily reached by omnibus across Blackfriars' Bridge. This is under the patronage of the Princess of Wales, that gracious king's daughter who has won the hearts of the English by the goodness of her heart no less than by the beauty of her queenly presence. This hospital was founded in 1841, and not only is the oldest of these special hospitals, but for many years was the only one of its kind. During the year 1886, the latest report obtainable, nearly six thousand patients were treated, of whom only thirty were inmates of the wards, and all of these latter were women. No men are received into the wards. The hospital is entirely dependent upon private support, receiving no governmental aid. I

am told that this is the case with all the London hospitals, they are all private institutions, and are nearly all in debt. The in-patients pay \$2.50 a week for their board. Oddly enough there is no house staff attached to the hospital. From this it results that any case requiring special care is sent to the general hospital to which the attending physician or surgeon may have access. The bad plan of charging the out-patients anywhere from twenty-five cents to \$2.50 for two months treatment, is in force here, according to their means; those paying the higher rate having the privilege of being seen by the physician before the others. The price they pay is printed upon their cards, and is further indicated by a difference in the color of the cards.

This system works as badly in London as in New York, patients attending the dispensary who can afford to pay a moderate fee to an outside physician. No charge is made for the medicine, and the truly poor receive treatment for nothing. From the patients there was received some \$3,250 in 1886. The hours of attendance are 3 P. M. on Monday and Wednesday and 2 P. M. on other days. It was in this hospital that Jonathan Hutchinson so long lectured to students, and his lecture room and picture gallery are still kept up, though the great man no longer lectures. On its medical staff are Jonathan Hutchinson, Warren Tay, Wyndham Cottle, and J. T. Payne. Mr. Tay, whose acquaintance I was so fortunate as to make, is one of the surgeons to the London Hospital, and a most genial gentleman. He is a strong believer in the virtues of tar for most all diseases of the skin, and in blistering with Burt's Blistering Fluid for alopecia areata. This fluid is a patented article and far more energetic than any other blistering fluid that Mr. Tay is acquainted with. His plan is to paint the bald spots with the fluid once every two weeks, and to use any indifferent ointment in the mean time to amuse the patient. He mentions several very remarkable cures by this method of treatment.

The other special hospitals for skin diseases are "The British Hospital" at 61 Great Marlborough street; "The Central London" at 227 Gray's Inn Road; "St. John's Hospital" at 49 Leicester Square; and the "Western Dispensary" at 179 Great Portland street. From what I have been told by the medical men I have had the pleasure of meeting, these institutions are of no great consequence, and what they said discouraged me from visiting them. We have already heard accounts of dissensions in the St. John's Hospital, but it would seem from what I hear here that not half the full truth has reached us. Matters have become so bad that a movement is on foot to obtain a decree from Parliament to close the hospital. No member of its medical staff can obtain entrance into The Dermatological Society of London.

Following the example of our own New York Dermatological society the gentlemen in London who are specially interested in the study of skin diseases have formed a dermatological society of their own. Its membership amounts to thirty, and its meetings take place at five o'clock in the afternoon of the second Wednesday in each month, excepting August and September. I notice on its list of membership the well known names of Anderson, Baker, Cavafy, Crocker, Duckworth, Colcott Fox, Hutchinson, Liveing, Stephen Mackenzie, Morris, Payne, Pringle, Pye-Smith, Sangster, Alder Smith, Showers and Thin. Our own Duhring is one of its non-resident members. I am very sorry that I arrived too late for their last meeting, as, from what several of its members have told me, they have a choice array of

cases at every meeting. The establishment of this society has further stimulated our English cousins to again follow our lead and to found a dermatological journal. This is to be under the management of Mr. Morris of London, and Dr. Brooks of Manchester, and the first number is to appear in October. Judging from what I have seen of Mr. Morris's work it is sure to be a wide awake journal.

The medical visitor to London will be surprised to note the great number of cases of ringworm and of alopecia areata. Where in New York we see one case of ringworm, here they see a dozen, and the proportion of alopecia areata cases is about the same. This proportion, I must say, is but guessed at, but I believe that it is not far from exact. The treatment of these diseases varies with the different physicians, but all agree that the matter of time enters very largely into the question of cure. All the stock remedies seem to have been tried, but I do not see that the results arrived at here are any better than those attained by us, nor that their methods of treatment any better than ours. Dr. Fox likes to have the hair cut short off ringworm patches, and for this purpose has adopted the hair clipping machine used by our barbers, which he calls his "lawn mower." When with him one afternoon at his admirable clinic room at the Westminster Hospital, a patient got off an unconscious joke that amused the doctor immensely. He asked her if she had been under treatment, and she replied, "No, Sir. I have only been to you."

The custom here is for the dermatologists to see their dispensary patients only once or twice a week. The afternoons are most often devoted to the work, but Mackenzie sees his patients at the London Hospital in the morning at nine o'clock, and Morris has the same hour at St. Mary's. The number of patients at each visiting day is large and some two or three hours must be given to seeing them. Some of the clinic rooms are admirably appointed and well lighted. Most of the medical men take students who sit around the teacher. The teaching seems to be of an eminently practical nature. Though this city offers a great deal of material for clinical observation on the part of the student, it by no means equals Vienna as a place for study, the distances being so immense that one must needs waste a great deal of time in going from one clinic to another. Here, however, is a good place for one who wishes to combine the tourist and the doctor, as the mornings can be given to sight-seeing and the afternoons to medical work under the courteous guiding of the London doctors and surgeons.

LONDON, Aug. 1888.

GEO. THOS. JACKSON.

## Foreign Correspondence.

*To the Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES :*

DEAR SIR—Although you always have such excellent letters from Germany and France, perhaps your readers may still be interested in a few out of the way notes gathered during my vacation.

Freiburg is a University town with quite an important medical school which, however, we do not often hear from in matters of dermatological interest. Since the death of Professor Hack the chair of dermatology, which

he occupied, has remained vacant, thus, for the time being, placing this on a par with the Universities of Heidelberg, Göttingen and other cities having no special department for instruction in skin diseases. In Freiburg, at the present time, dermatological cases are made part of the general surgical service, at the head of which is Professor Kraske with Dr. Middeldorpf, who is also a *privatdocent*, as first assistant. The number of skin cases is limited, but together with venereal diseases, which also belong to this service, make a good showing. Kraske has had good success in the treatment of chronic ulcers of the leg by the following method: He first scrapes out the base and edges of the ulcer with a Volkmann's sharp spoon, removing all granulation and unhealthy tissue, and then applies to the resulting raw surface very thin strips of skin, shaved from some portion of the patient's body with a razor. The strip of skin, usually taken from the opposite leg, is made as thin as it is possible to shave it off, and the resulting denuded surface quickly heals under an antiseptic dressing. The ulcer heals much more rapidly than after transplantation with small skin grafts. Kraske spoke of this way of treating obstinate ulcers of the leg at the

#### Congress of Physicians of the Upper Rhine

which was held in Freiburg about the middle of this month. He also read a paper upon the importance of immediate operation in injuries to the urethra from falls and blows upon the perineum. In such cases, where blood passes from the canal, he cuts down at once to prevent urinary infiltration. If it is possible, the torn ends of the urethra are caught up and sutured, but if not, the wound is left open for drainage. If I am not mistaken this has been the teaching of Professor Keyes for many years. At this same meeting, which was a purely scientific one, but in which the papers were not discussed, Professor Bäumler spoke of prophylaxis in scarlatina. He regards the period of six weeks, which the French Academy has put down as the length of time a patient is dangerous to others, as too short, and maintains that there are cases in which the disease may be transmitted by the patient after sixty and sometimes even eighty days. Wherever it is practicable he advises absolute isolation of the patient, rigid disinfection during the course of the disease, and the most careful disinfection of the apartment, bedding and clothing afterward. There is nothing in Freiburg to tempt a man who has come to Europe to study dermatology. Vienna, with such eminent professors as Kaposi and Neuman, and such able docents or instructors as the younger Hebra, Jarisch, Finger and Grunfeld for skin diseases, and Mrazek and Zeissl for syphilis, must still draw to the banks of the Danube, as it has for many years, the great majority of science-seeking Americans. Here not only are good instructors abundant, but the number of cases is almost unlimited. One feature of medical study in Vienna which is of great advantage, is the concentration of all work in the *Allgemeine Krankenhaus*. In Paris, of course, a man devoting himself to this branch alone, can spend most of his time in the St. Louis Hospital, but if he is combining other studies with dermatology he must of necessity lose much time running about.

Individual teachers of dermatology in other parts of Germany will draw to themselves a certain proportion of American students. Unna in Hamburg, Pick in Prague, Schwimmer in Buda-Pest, who are all so well known by their writings and teachings, will be sought by advanced students and those making a special study of the skin. Pick and Schwimmer are



professors in their respective universities, and Unna has a private hospital of his own, with abundant facilities for giving instruction. I have just been looking over a recent work by Schwimmer upon the

### Therapy of Syphilis.

(Die Grundlinien der heutigen syphilis therapie.) It is an excellent presentation of to-day's methods, and a review of the various ideas which have been held in the past as to how the disease should be dealt with. Schwimmer is very decided in regarding an expectant treatment as objectionable. His experience has taught him that early treatment is of the greatest importance as regards both the course of the disease and its after effects. The following three questions are proposed and ably answered: I. What means will best protect the system from an outbreak of syphilis? II. What means can best be instituted to combat syphilis which has already broken out? III. What length of time can be regarded as sufficient to free the individual from his syphilis? The answer to the first question is negative. The author knows of no reliable means of preventing an outbreak of the disease. He finds neither in cauterization nor in excision of the primary lesion a sure prevention. In some suitable cases excision may be practiced, and he himself has seen a freedom from symptoms in two consecutive instances out of twelve cases in which he has practiced excision. Still the true worth of the method must yet be regarded as problematic. To the second question the answer is "mercury," especially in form of inunctions, and second choice is given to injections. As an introductory cure before these more powerful means are used, he recommends corrosive sublimate in pill form or in solution, and between the inunction and injection courses combinations of mercury and iodide of potassium. As to the third proposition an answer cannot be made positively with our present knowledge, but he thinks that from a year and a half to two years, if intelligently carried out, treatment which has been begun early and occasionally interrupted will prove sufficient in most cases. He has used the hydrargyrum oxydulatum tannicum recommended by Lustgarten with good effect, but has found that contrary to Lustgarten's opinion, it would in some cases produce diarrhoea and salivation. The following formula is given for this drug in pill form:

R Hydrarg. oxyd. tannici.....	3. o.
Ext. et Pulv. Liqur.....	q. s.
Ft. pil. No. 60 S. 2-4 daily.....	

The employment of vegetable substances is passed in review from the time of the Sixteenth Century, when the *Lignum sanctum* was brought from India, and sarsaparilla and sassafras roots gained their reputation. Zittmann's decoction is well spoken of for inveterate, obstinate cases of syphilis, in which especially mercury is not well tolerated. All these decoctions, which do not contain mercury or the iodide, must be regarded as Diuretica, Diaphoretica, and Stomachica, and their good effect thus accounted for. He does not give Zittmann's decoction in the enormous doses formerly prescribed, nor does he keep his patients upon a starvation diet while they are taking it, but usually orders the patient to take each morning 250 to 300 grams (38-310) of the stronger decoction warmed, and to remain in bed for two hours thereafter. Then a light breakfast is to be taken. The same quantity of the weaker decoction is to be taken upon going to bed. While in bed the body must be kept well covered to aid the diaphoretic action. The diet, during the course

of treatment (4-6 weeks) must be light. Five hundred grains of this decoction contains eight decigrams of calomel and two decigrams of cinnabar. In place of this more expensive preparation, he uses in hospital practice the following formula :

R Rad. Sarsaparille, Rad. Bardanae.....ää 50  
Ligni Sassafras.....ää 30

Two spoonfuls of this is added to a litre and a half of water, which is boiled down to a litre, filtered and divided into four doses, one to be taken morning and night. At the same time the patient is given a pill of corrosive sublimate containing from 1-20 to 1-12 of a grain. The author regards it as still an open question whether the chrome water or chromate of potassium proposed by Gtintz (Leipsic, 1883) can be given a place among the known curative agents. Syphilization, Balneotherapy and Hydrotherapy are fully considered. He says a bath cure alone, without the concomitant employment of drugs, has no influence upon the course of the disease. On the contrary, he has often seen latent syphilis brought out, and patients who appeared free beforehand after a prolonged bath-cure would show again the later manifestations of syphilis. In treating any case it is not only necessary to choose the proper remedy, but we must consider the individual as well, and also the form of the disease.

### Infection of Syphilis.

I have also been interested in reading a recent brochure from the pen of Professor Bergh of Copenhagen, upon the infection of syphilis and the various ways in which it may occur. A subject of extreme interest in itself now that *syphilis insontium* is so frequently encountered, but perhaps of especial interest to me because this was the subject of my graduation thesis, and I could but note the real advances which had been made in our knowledge of the modes of infection even during the past ten years. The discovery of a microbe which in all probability is the agency by which the disease is transmitted, has made clear certain modes of its infection which were previously obscured. Bergh believes we can provisionally accept it as a fact that the physiological secretions are not virulent unless mixed with blood or with the secretion of virulent lesions. Also that the unmixed purely pathological secretions, as that of urethritis, leucorrhœa, eczema, vaccine, lymph, etc., even in the early period of syphilis, have no virulent properties. Infection takes place either directly, as in sexual intercourse, or indirectly through the medium of an intervening agency. Of the many interesting modes of direct and indirect infection mentioned, I will give a few instances : From sucking out wounds in persons who have been found to be syphilitic. From performing insufflation on new born syphilitic children. From having a syphilitic patient spit into the eye during an examination of the mouth or throat. From carrying a child upon the bare arm, mucous patches being present upon the child's buttocks. Infection from circumcision has become so common among the Jews that in many Jewish communities a scientific surgical operation with antiseptic precautions is insisted upon. Transfer of the disease through tooth transplantation as well as through transplantation of skin are mentioned. It is considered a remarkable thing that nothing has been written upon the question of infection from the cadaver of syphilitics who have died in the secondary stage of their disease. The author thinks an instance of this mode of infection has been experienced at Copenhagen.

Instances are recorded of the disease being contracted from masks and gloves, and from bed clothing which had been in contact with mucous patches or other lesions, and become soiled with their secretion. Such an instance of infection from a bed fellow the author thinks to have seen, and it seems to me not unlikely that this was the mode of transfer of the virus in the family of syphilitic children presented by Dr. Taylor at the Dermatological Society last year. The author does not regard it as impossible that the handkerchief may act as a medium, or that the disease may be contracted by washing the linen of a syphilitic subject. The fear of infection from the communion cup which received some attention in our country a year or so ago, is shown to have been written upon at some length in the last century (1787). Mouth pieces of musical instruments, children's toys, trumpets, etc., have been found to serve at times as bearers of the poison. As early as 1504 Cataneus showed that syphilitic virus could be conveyed by a person in transit, so to speak, and without becoming infected himself he could deposit the poison upon the person of another who would suffer its consequences. The virus can thus be carried upon the genital organs or upon the finger without gaining access to the body, and still infect the next individual with whom it comes in contact. Nurses in lying-in hospitals have thus in careless examinations carried the disease from one woman to another. The author doubts whether prostitution will ever disappear from the world, but thinks its evils can be greatly diminished by bringing it under proper control. Hospitals should be freely opened to syphilitics, but the greatest care should be exercised in keeping these patients and their utensils separated from the others. If practical it would be very desirable to require certificates from those about to marry, that for several years they had been free from syphilis. A popular knowledge of the nature of the disease, its powers of infection, and its dangers would also aid in limiting its distribution and destructiveness.

I am reminded of the very interesting letters, from Paris to the JOURNAL last year from you, Mr. Editor, by those I have just been reading from Unna to his *Monatshefte*. Nowhere in the world will be found so many bright men working together in the field of Dermatology as in Paris and nowhere else would there be such harmony, so much pulling together, such common scientific interest, and nowhere else probably would the visitor from a foreign land be so well taken care of. I am therefore greatly pleased that those men of the St. Louis hospital whom we all know so well, without perhaps ever having had the pleasure of a personal meeting, have taken the initiative in organizing an international Dermatological and Syphilographical Congress for next year. What a treat that will be for all who can get there. How sure one could feel that here, of all cities, a dermatological congress would be a great social as well as a scientific success. Ricord, whom all Americans honor and take a pride in as a product of our soil, though to be sure he was transplanted early in his career, has accepted the honorary presidency of the congress, while Professor Hardy will fill the functions of presiding officer. America should be well represented and help to make this, the first international congress of dermatologists, what it will surely be—a grand success, a noteworthy event in the history of dermatology as a separate branch of medical science. While in Paris I had the pleasure of meeting your correspondent, Dr. Brocq, whose letters to the JOURNAL I read with such interest. I spent a morning with him at St. Louis hospital and saw many interesting cases. Among them was a beautiful example of

### Dermatitis Herpetiformis.

It had greatly improved in a fortnight under internal treatment alone, consisting of quinine and extract of belladonna. I learned that a number of well marked cases had recently been seen in the wards, and that the diagnosis was now a well recognized one, and the work of our honored countryman, Duhring, was duly appreciated. Brocq has recently written a rather lengthy critical review of the whole subject of Dermatitis Herpetiformis in the *Annales de Derm. et de Syph.* Nos. 1-6.

### Ulcers.

There is a vast difference in the results of treatment of ulcers, in hospital and in dispensary practice. In the St. Louis wards, ulcer cases remain in bed, as they should, and consequently success is more apt to follow any given line of treatment. I saw ulcers which were doing remarkably well, under the sole application of powdered carbonate of iron, applied in a thick layer, and this, by the way, is the favorite and almost routine treatment in some services. I also saw several ulcers which were healing under scarification of the borders and base. Vidal's scarifying knife is used and quite deep linear or quadrilateral cuts are made through the surrounding dense tissue, the hardened border of the ulcer, and, if needs be, the base. After healthy granulations have filled in the base, it is only necessary to extend the cuts through the borders of the ulcer.

### Psoriasis.

I was struck with the number of cases of Psoriasis in the St. Louis attended with arthritic deformities. Contracted joints, crooked fingers, or chronic rheumatism in active progress, seemed to be rather the rule than the exception. I have always believed in a connection between or association of psoriasis and the arthritic diathesis, and always try to inquire into a psoriatic patient's history in reference to rheumatism, without, however, always discovering it; but here the concomitance of the affections is surely striking. I understand that a thesis upon the subject of psoriasis and deformities of the fingers is soon to appear, based upon observations made at this hospital. Vidal treats psoriasis by preference with vigo plaster, applying it to a limited region at a time, while Brocq gives his preference to oil of cade. Chrysarobin he has found is not always well supported, and has been known to result in the death of one patient. I was interested to learn that this gentleman had met with much the same experience as myself in the employment of pyrogallol, finding that now and then, without any apparently good reason, it would produce destruction of tissue to an alarming extent. He has had several such disastrous results as I relate in my paper, on the use and dangers of this drug, which appeared in the January 1886 number of the JOURNAL. He was at first inclined to attribute part of the ill effects to the collodion in which it was dissolved, but I believe the pyrogallol was alone to blame. Collodia dressings do not appear to find much favor here.

### Lepra.

Several cases of this, to me very interesting disease were seen in Vidal's service the morning this eminent professor took me with him on his rounds.

Two cases were improving under chaulmoogra oil in daily dose ranging from ninety to a hundred and eighty drops. One patient told me he had taken as high as two hundred and ten drops one day. The tubercles were flattening down under the treatment, and there appeared to be a general improvement. I asked Vidal if he ever used his scarifier to remove the deforming lesions of lepra upon the face, but he said he had never found it necessary. At the time I read my paper on lepra at the County Society and showed the patient whose face I had operated upon, I said I had not been able to find any account of the results of surgical operations among lepers, and had been pleased to note the remarkably kind way in which the wounds healed in my patient even under a blood clot, without antiseptic dressing. I have just read in *La Semaine Médicale* that Dr. Rake reported at the last British Medical Association that, having discovered at the autopsy of a leper an aneurism of the aorta completely obliterated, and cured by the formation of very firm clots in concentric layers, he was led to undertake a series of experiments at the Trinidad hospital, to determine the amount of fibrin present in the blood of lepers. The patients used in the observations were affected by lepra in its varied forms, and the blood was obtained in the course of surgical operations. It was observed that these patients recovered rapidly after surgical operations, and that cicatrization seemed to be more rapid than in ordinary surgical cases. The blood was noted to clot rapidly. The proportion of fibrin varied from 0.12 per cent., to 1.87 per cent., or a mean percentage of 0.76 while normal blood contains 0.2. The reduction agents are now generally employed, and with benefit, I believe, in the treatment of the leper cases in the several services of the St. Louis hospital, but I also believe it is a mistake to treat so many lepers in the heart of a large population, and to allow them the freedom these patients enjoy.

### **Eczema Seborrhoicum**

is a diagnosis which one now frequently hears made in the Paris wards. Like dermatitis herpetiformis the condition was known long ago, but it required such description as Unna gave to the one and Duhring to the other, to place the names on a firm footing and make their employment bring into the mind a definite pathological condition. Seborrhœal eczemas which would formerly have been given a variety of names according to their formation, dryness, scaliness, redness, etc., are now recognized as due to the same conditions and are more simply designated, while some conditions not then regarded as eczematous at all are now admitted to be properly called eczema seborrhoicum.

### **The Baretta Museum.**

Many of those who have not had the good fortune to see the beautiful collection of wax models of skin diseases upon which Baretta has been at work for many years, may at least have seen an excellent example of these works of art in the collection which Dr. Bulkley keeps at the New York Hospital to illustrate his lectures.

To properly appreciate this St. Louis Museum weeks of study would be required, and only an idea of its importance can be obtained in passing through. Dr. Brocq devoted part of a morning to me here, and I was thus enabled to see in a comparatively short time many of the casts which in-

terested me most, and to enjoy them the more thoroughly. I asked him to show me first the model of

### Molluscum Contagiosum by Inoculation

to which Unna's letter had called my attention. In asking one of his assistants to look for it I observed that he used the term *acné varioliforme*, and I was tempted to ask whether the possibility of inoculation which the cast illustrated, had not suggested a change of nomenclature, but my companion's talk was too interesting to be broken into with much questioning. I was anxious to see the result of Mr. Pautry's inoculation, for all of my attempts had failed, the nearest approach to a positive result being the production of a papule upon my own arm. I knew that inoculations had been successful with others, and had quoted this case, as well as another reported by Vidal and one by Retzius, in a paper on the subject which appeared in your JOURNAL of August, 1886, but I must say I was surprised to see what a perfectly typical lesion had been produced upon an infant's arm in this case. This cast having no further interest than the fact of inoculation, we passed on to the lupus group. Here is surely a rare collection and a valuable one to study, were it not that the St. Louis wards have always so many actual cases under treatment which one can see more profitably. One model had just come in from Baretta's studio. It was the face and hand of a man whom I had seen in Vidal's service. A lupus of the face, upon which as a base, an extensive epithelioma had developed and destroyed a greater portion of the nose. The hand showed that form of lupus which they term *lupus corné*, with heaped up horny masses upon the dorsal aspect of the fingers. This model was so life-like, so true to nature, that it seemed as though the patient's own face and hand had been cut away from his body and placed upon a board in the case, and showed me how accurate in form and coloring is the work of this renowned artist in wax. Here all skin eruptions may be found modeled so true to nature, that the study of dermatology could be carried on without patients, and a greater variety of rare cases seen in a day than one would see in a life time. Unfortunately for the student, however, the labels attached to them are in many cases misleading so far as diagnosis and classification are concerned. It has been proposed that the collection should be re-labeled, and the older names and misleading terms done away with, and the whole re-classified and grouped. This would undoubtedly make the museum of greater value to students, but, I agree with Unna, that it would be a great misfortune to remove the original labels from the early contributions and thus rob the collection of this graphic portrayal of the views of many excellent men who have gone before, and the standpoint from which they wrote. As it stands to-day, the collection presents at once to the eye a whole Century's history of dermatology in France. Among the more recent additions one represents a case of dermatitis herpetiformis, in which quite large bullæ occupy the axillary region. Were the collection to be re-labeled to-day, it would probably happen that in twenty years it would be found desirable to again replace those labels with new ones, and in the absence of the history of this case it would probably be placed in the pemphigus group. Re-grouped or left as it is, the Baretta Museum is surely worthy of not one visit alone but of many.

BADENWEILER, GERMANY.

CHARLES W. ALLEN.

## Selection.

### RUPTURE OF THE URETHRA.

DR. IVESSEN (*Nordiskt Medicinskt Arkiv*, Bd. XIX., 1887), bases his extensive paper upon the histories of twenty-nine cases observed in the hospitals of Copenhagen. He believes that most frequently the rupture is partial, implicating the inferior and lateral walls, and frequently takes place at from 1 to 3 centimeters anterior to the triangular ligament of the urethra, that the membranous portion is rarely torn and as a rule secondarily to lesions of the bony pelvis (fractures of the bones or dislocation of the symphysis pubis). He relates six cases of rupture of the membranous portion, one only of which recovered. The autopsy permitted it to be clearly shown that the rupture of the membranous portion was caused either by a fracture of the pelvis, or a dislocation of the pubis and the sacro-iliac synchondrosis.

In symptomatology the author makes a vigorous distinction between the two forms of rupture of the urethra. 1. That which takes place in the perineo-bulbous portion, at from 1 to 3 centimeters anterior to the triangular ligament of the urethra, and, 2., that of the membranous portion. The symptoms of the first, are : 1st, urethrorrhagia ; 2d, swelling in the perineum ; 3d, difficult passage of urine, manifesting itself in general in the form of retention, which is so often of benefit to the patient in that it saves him from that dangerous accident, extravasation of urine. In the second form hemorrhage from the urethra is only seen as an exception, and in any case is insignificant ; there is no primary swelling of the perineum, but what is especially characteristic is the rapid extravasation of urine favored by the rupture, which paralyzes the functions of the external sphincter of the bladder in the membranous portion, so that the bladder responds to every slight call to urination, and pours out its contents in the superior chamber of the perineum. The urine following the course of the pubo-prostatic ligaments rapidly sets up a pelvic cellulitis, which is followed by septic trouble and accompanied by peritoneal symptoms, and followed in a few days by death or more rarely by a phlegmonous tumor in the ischio-rectal region, appearing alongside of the anus. Thus when after this lesion distention of the bladder is not to be made out, this circumstance has a serious importance.

The author recommends careful examination of the urethra with an olivary bougie à boule before trying the catheter. Operation can only be avoided in cases not very serious. The catheter à demeure may be used of if an able assistant is at hand, periodic catheterization, but here at the first swelling of the perineum the incision must be made. In serious cases of rupture in the perineo-bulbous region we are often obliged to practice external urethrotomy at once. In complete rupture a soft catheter should be passed the whole length of the canal. This may be left not longer than eight or ten days especially when the rupture has only been partial. In the subsequent treatment he used Guyon's bougies to obtain inflammatory atrophy of the granulations. If the rupture is complete and exploration of the posterior extremity impossible, he recommends the hypogastric incision with subsequent catheterization of Brainard to secure the introduction of a catheter à demeure in the whole length of the urethra.

In the treatment of ruptures of the membranous portion it is necessary in general to make the hypogastric incision in order to be able to introduce a guide into the whole length of the urethra, after which a median or bilateral section is done, so as to open up as much as possible the superior portion of the perineum. In this case as well a canula *à demlure* must be immediately introduced.

Finally, Dr. Ivessen calls attention to the cicatricial stricture which is sure to follow, and which may a few weeks after the lesion require attention.

## Items.

**GLYCEROLE FOR PIGMENTARY SPOTS ON THE SKIN.**—Dr. Unna prescribes the following :

- Oxide of bismuth,
- Rice starch ..... ā ā 2 grs.
- Kaolin..... 4 grs.
- Simple glycerole..... 10 grs.
- Distilled rose-water, q. s.

Put this mixture on the pigmentary spots and let it dry. Bathe carefully before making the application.—*Le Clinique*.

### **SALOL COLLODION FOR CHAPPED NIPPLES.**—

- R Salol..... 4 gr.
- Ether..... 4 gr.
- Dissolve and add,
- Flexible collodion.....30 gr.

### **LOTION FOR VULVAR PRURITUS.**—

- R Decoction of Walnut leaves.....500 gr.
- Borax..... 5 gr.
- Benzoin..... 40 gr.

Mix.

Apply several times daily.

**ECZEMA OF ARMS AND GENITAL ORGANS.**—For this painful complication of uterine affections, Lustgarten proposes the following :

First. Hot Sitz bath with use of soap.

Second.

- R Oleate of Cocaine.....40 centi-gr. to 1 gr.
- Olive Oil..... 2 gr.
- Lanoline.....10 gr.

Mix and anoint affected parts twice daily.

**OBJECTION TO THE USE OF THE INSOLUBLE SALTS OF MERCURY SUBCUTANEOUSLY.**—Balzer and Mlle. Klumpe have found that the subcutaneous injections of the insoluble salts of mercury, calomel and yellow oxide for example, are ordinarily accompanied by local nervous lesions. The practical conclusion which follows is that if such lesions do not constitute an absolute obstacle to the employment of such injections, they should, at least, restrict their use and require the administration of smaller quantities. (*Le Progrès Médical*.)





**Journal of Cutaneous**  
**and**  
**Genito - Urinary Diseases.**  
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JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

NOVEMBER, 1888.

No. 11

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**Original Communications.**

CASE OF TUBERCULOSIS PAPILLOMATOSA CUTIS WITH REMARKS ON THE RELATION OF PAPILLOMA TO SYPHILIS, LUPUS, ETC.<sup>1</sup>

BY

P. A. MORROW, A.M., M.D.

*(Continued from page 370.)*

I HAVE been thus minute, and I fear tedious, in the description of the clinical features of this case as well as the different phases of its development so far as could be obtained from the records which have been preserved. These latter, though meagre, are peculiarly interesting and I think valuable in elucidating the nature and mode of origin of the morbid process.

The diagnosis of syphilis was excluded by the character of the initial symptoms, its sluggish mode of development and chronic course, the absence of concomitant symptoms of syphilis, and by the absolute failure of specific treatment to arrest or in any way materially modify its evolution. In addition there was an absence of the hard brownish red infiltration of the margins which is regarded as the most pathognomonic feature of the vegetating syphilide.

There next remains to be considered the relations of this

<sup>1</sup> Read before the Congress of American Physicians and Surgeons, Washington, September, 1888.

hyperplastic growth to lupus verrucosus and that form of tuberculosis of the skin which has been described as tuberculosis verrucosa cutis. It would be foreign to the purpose of this paper to enter into a consideration of the substantial identity, or the distinct and independent nature, of lupus and tuberculosis. Incidentally it may be said that many of the leading dermatologists of the present day recognize in lupus a form of tuberculosis. Proof of the identity of the two diseases is based upon the pathological anatomy of the lesions, their evolutive characters, the discovery of the bacillus of Koch in lupus products, the results of inoculative experiments and, finally, clinical observation.

Leaving aside the evidence furnished from a bacterial standpoint, which is by no means absolutely conclusive, it must be admitted that the high percentage of deaths from tuberculosis of other organs occurring among those affected with lupus, affords strong presumptive proof of the close connection between the two diseases. Besnier and Lailier found twenty-one per cent. of lupus patients affected with tuberculosis in some other organ. Doutrelpont found in thirty-eight lupus patients fifteen whose antecedents were tuberculous. Leloir found out of nineteen patients with lupus ten incontestably affected with pulmonary tuberculosis. Still more significant are the statistics quoted by Dr. G. T. Elliot in a recent paper on "Tuberculosis Verrucosa Cutis." According to Block it was seventy-nine per cent; Sachs sixty-two, eighty-three hundredths per cent; Bender sixty-two, three hundredths per cent. Added to this is the frequent development of acute miliary tuberculosis after operative procedures made upon lupus. Besnier observed such a large proportion of cases in which scarification of lupus was followed by pulmonary tuberculosis that he has practically abandoned this method of treatment.

For purposes of comparison as well as to bring more clearly the points of similarity as well as of dissimilarity between the clinical features of my case, the verrucose form of lupus and tuberculosis verrucosa cutis, it may be well to briefly refer to the clinical characteristics which have been described as peculiar to these diseases.

The term lupus hypertrophicus is generally employed to designate a metamorphic phase of lupus vulgaris. After the tubercles break down and become ulcerated, the floor of the ulcer may become the seat of papillomatous proliferations or warty formations.

That form of lupus described by Vidal as *lupus sclereux*, and previously by McCall Anderson as *lupus verrucosus* or *scrofuloderma verrucosum*, is not preceded by ulceration, but the warty growth is a primary essential part of the process.

According to Dr. McCall Anderson's description, there are in it no yellowish-red nodules as in *lupus vulgaris*, but it begins by the development of small circumscribed dusky-red patches, often in the form of tubercles, which may be isolated or run together. The patches, the whole or in part, become the seat of wart-like excrescences—the extreme edge continues free and forms a violet purplish-red border. The warty formations can be picked off without much pain, but readily reform. There is no ulceration beneath, but the parts are greatly hypertrophied. The course of the disease is sluggish. Eventually the patches flatten, pale and a smooth cicatrix marks the site of the eruption. Its seat is commonly upon the extremities, especially the hands and feet, but it may develop upon any part of the body. It occurs chiefly among half-starved and neglected children. Anderson refers to its resemblance to *verruca necrogenica*.

Compare with this Vidal's description of *lupus sclereux*. This form of lupus may develop *d'emblee*, that is primarily, or as a secondary phase of transformation of tubercular lupus. Sclerous lupus is characterized, clinically, by more or less extensive patches, neatly circumscribed, deep-red or violaceous in color, around which the derma becomes thickened and indurated, the papillæ are exceedingly hypertrophied, forming rugous, uneven mammelated protuberances, covered at certain points with verrucose excrescences, sometimes of a corneous appearance, separated from each other by fissures and furrows, discharging a purulent secretion. Frequently the centre of the patch heals by a sort of sclerous transformation, while the lesion advances at the periphery pursuing a serpentine course. Its seats of election are the fingers, hands and toes. According to Leloir, *lupus sclereux* bears the same relation to *lupus vulgaris* as does fibrous tuberculosis of the lung to ordinary tuberculosis of this organ.

Under the designation of *tuberculosis verrucosa cutis*, Riehl and Paltauf have described an eruption, the characteristic features of which consists of various sized patches, constituted by three concentric zones, the outer consisting of a bright red erythematous band, not perceptibly elevated; within this band another zone composed of small superficial disseminated pus-

tules, brownish or livid-red in color; in the centre the patch becomes more raised, the surface irregularly prominent and covered with papillomatous or warty growths with club-shaped or pointed ends, some of them 5 or 7 millimetres in height. Between the papillomata are fissures and small erosions from which, upon pressure, numerous drops of pus escape. The lesion extends at the periphery, while healing at the centre. Retrogression is slow, but it heals spontaneously, leaving thin cicatrices with a sieve like or fine net form appearance. The only subjective symptom is a sensitiveness to pressure, sometimes amounting to pain. The eruption is limited to the backs of the hands and sides of fingers, and occurs in vigorous subjects, whose occupation brings them in contact with animals or animal products. Riehl and Paltauf claim that it differs from lupus by the absence of brown-red nodules, in its advance being accompanied by inflammatory symptoms and showing *no tendency to ulceration*.

Riehl and Paltauf admit the resemblance of this form of cutaneous tuberculosis to verruca necrogenica, the origin of which from the accidental inoculation of tuberculous material is generally held. An examination of an anatomical tubercle removed from the hand of Dr. Kalisko, showed identical histological characters with those found in tuberculosis verrucosa cutis. Their identity is farther probable from the demonstrated presence of tubercle bacilli in both forms. There would then seem to be no essential difference between the two except in the origin of the former from the cadaveric tissues of the human body, and of the latter from the inoculation of tuberculous matter from the lower animals.

From the comparison of lupus verrucosus or lupus sclereux with tuberculosis verrucosa cutis, it will be seen that they present many analogies, they do not differ materially in their typical papillomatous features, they are identical in location, and notwithstanding Riehl's assertion to the contrary, an absence of ulceration is common to both; but while lupus verrucosus is more common in strumous subjects before the age of puberty, tuberculosis verrucosa cutis occurs in healthy and vigorous adults.

Notwithstanding the salient points of difference in the clinical manifestations of my case, and those just described I am inclined to believe that it is a cutaneous tuberculosis. This view is supported by the results of the microscopic examination of the growth, its genesis and evolutive characters, the presence of



tubercular or scrofulous gummata and their characteristic cicatrices.

Sometime since I excised three pieces, two from the margin of the patch on the cheek, the other from the upper lip, and submitted them to Dr. George T. Elliot, of New York, for examination. A few days ago he sent me the following report:

"The three specimens were hardened in absolute alcohol, mounted in collodion and, having been cut into sections, were treated in various ways. A portion of the sections were stained with borax, carmine, etc., while the others were subjected to Ehrlich's method for tubercle bacilli. The first specimen allowed no conclusion to be made, it not having been cut deep enough and only showing the general changes seen in the epidermis and upper half of the papillæ of an ordinary papilloma.

"The second specimen from the cheek allowed the characteristics of a granuloma of tubercular origin to be recognized. Small tubercles, giant cells, epithelioid cells and granulation tissue were found, situated for the most part high up in the corium, and also in the papillæ themselves. There was also a considerable amount of inflammation, but there were no changes in the blood-vessels indicative of syphilis.

"The sections treated by Ehrlich's method showed the presence of tubercle bacilli. There were only a few found in the tubercles and in their neighborhood. The third specimen from the lip was treated in the same way; there was much less infiltration of the tissue present, but high up in the papillæ exquisite tubercular tissue was found, and also in properly treated sections a few bacilli.

"From the result of the microscopic examination it is possible to conclude that the papillomatous growth was tubercular in its nature and represented a tuberculosis cutis."

In endeavoring to trace the genesis of this disease, the possible relation of the osteopathy of the joint must not be left out of consideration. The nature of the joint trouble unfortunately can only be surmised from the imperfect history, which merely notes that the amputation was performed for malignant disease. In the absence of positive data I am disposed to believe that the disease was *tubercular osteitis*—the sinuses, discharge and necrosis resulting from tubercular infiltration. Statistics show that primary tuberculosis is quite common in the bones of the forearm and metacarpus. As the entire mass of diseased bone was probably not removed, a second amputation at the elbow joint was necessitated.

I would regard the tubercle which appeared on the left side of the nose three or four weeks after the joint became swollen and

suppurating, as the result of auto-inoculation. The opportunities for the direct transfer of tuberculous material from the back of the hand to the face are innumerable, and in rubbing or scratching the left side of the face the left hand would naturally be used. Instances of auto-inoculation are rare but well attested. Morel Lavallée in a recent brochure, "*Etudes Experimentales et Cliniques sur la Scrofulo-Tuberculose de la Peau*, p. 164," cites a number of cases in which lupus was auto-inoculated from tuberculosis of the bones and other structures; 2 cases of Besnier, 1 of Leser, 2 of Volkmann, 1 of Liebricht, and one which came under his own observation, in which tuberculosis of the metacarpus was followed by sclerous lupus of the hand.

The evolutive characters of the disease pronounce strongly in favor of its tuberculous nature. The morbid process has been slow and sluggish in its development. The lesion on the face commenced as a tubercle, which was verrucose from the first. The papillomatous proliferations have developed without any preëxisting ulceration. They advance for the most part by continuity of tissue at the periphery, but fresh foci of disease have developed at points distant from the central disease. I had an opportunity of watching the advance of the outgrowths upon the left eyelid. The lesions appeared at disseminated points as small pin-head sized papules with a large base upon apparently normal skin, as the papules enlarged, the epidermis disrupted in the centre, and small pea-sized vegetations sprouted forth. By the development of similar lesions in their immediate contiguity, the entire lid gradually became covered with aggregated masses of vegetations. The hole in the left nostril would seem to indicate an ulcerative process, the patient states, however, that three or four months previous to his admission, on account of the atrocious itching, he hooked a long finger nail in one of the protuberances and tore out a large mass of tissue forming an opening into the nostril. The ala may have been weakened by caseous degeneration, or by the operation referred to in the notes of the case, where "a piece as large as a silver quarter was removed from left side of the nose, the surface cauterized and the left nostril burned out with the actual cautery."

I regard the glandular enlargements which were especially marked on the right side of the neck as of the nature of the *gommès scrofuleuses*, or the *gommès tuberculeuses* of the French. They presented many analogies with a case of *lupus verrugueux* of the hand, attended with a gummous lymphangitis of the forearm and arm of a scrofulo-tuberculous nature, which

I had an opportunity of observing in July, 1887, in the Hôpital St. Louis, Paris, and which has since been reported by Morel Lavallée in the *Annales de Dermatologie et de Syphiligraphie*, January, 1888. The nodules of variable size, one as large as a mandarin were disposed in vertical series along the anterior face of the arm, forming interrupted cords. As they mounted upward to the deltoid, the tumors became larger and more fluctuating. The gummous lymphangitis in my case presented almost identical appearances, only the tumors increased in size toward the root of the neck as they followed the course of the descending lymphatics.\* It will be remembered that the cicatrices which have followed the involution of these tumors are quite characteristic of scrofulous scars in their uneven, ridgy and bridled aspect.

Having thus traced the links in the genetic chain which connects the papillomatous lesions of the face with a primary tuberculosis of the bones, and thus established their tuberculous nature, the prognostic indications are worthy of a moment's consideration. According to M. M. Vallas (*Sur les ulcérations tuberculeuses de la Peau, Thèse de Lyon*, 1887, No. 367), in the case of lupus, or verrucose tuberculosis, when the tubercular bacillus invades the healthy external integument "the rule is to see the affection evolve slowly, to retrocede gradually and finally to be cured by the fibrous transformation and encystment of the infectious nodules." In Riehl and Paltauf's case there was no general infection; after a duration of from two to four years the disease spontaneously disappeared.

M. A. Lefèvre, (*Sur la Tuberculose par inoculation cutanée chez l'homme Thèse de Paris*, March, 1888,) gives a resumé of thirty cases of tuberculosis contracted by the external integument, including all published up to that time in which the authenticity was placed beyond all doubt, and the evolution of the disease had been followed and related. In twelve of the cases the observation stops after the mention of adeno-lymphite bacillaire; osteo-arthritis seven; having necessitated amputation two (1 not cured); general and pulmonary symptoms three; spinal meningitis one. In two cases the patients died of a different disease.

In the remaining sixteen cases, there was an infection of the economy in diverse degrees in fifteen, death occurred in nine, in three cases from tubercular meningitis; in four cases from consumption due to disseminated lesions; in one case from *granulie*; in one the details are wanting.

In six cases secondarily infected by propagation, and which survived, five were cured; one after having presented adenolymphitis; three scrofulides; one suppurating arthritis; one patient was in good health after having presented adenolymphitis and pulmonary symptoms. Of these thirty cases, thirteen had origin in the operation of circumcision among Israelites and the suction of the wound by a tuberculous operator.

Only eight of these cases were of the non-ulcerous, papillomatous or verrucose form. Of these, three were followed by pulmonary or visceral infection, one by osteo-arthritis, and one by specific adenolymphitis.

As these thirty cases related to "spontaneous primitive infection of the integument, anterior to any other localization of tuberculosis" their direct bearing upon the prognostic indications in my case, is very much restricted, assuming that the lesions of the face represent a secondary inoculation. There are no statistics to which we can appeal; after more than three years, however, my patient exhibits no evidence of general infection.

The implication of the lymphatics would seem to forecast an unfavorable prognosis. Leloir has reported a number of cases in which a lupus focus of the hand became the origin of tubercular lymphangitis, with production of scrofulo-tuberculous gummata developed along the course of the affected lymphatics, and determined finally, by absorption of the tuberculous virus of the upper extremity, a pulmonary tuberculosis of the corresponding side.

Finger has recently reported (*Med. Wochenschrift*, No. 5, 1888) a case of tuberculosis cutis verrucosa, in which the patient died, æt 41, of general tuberculosis. On his left forearm and back of hand were five verrucose plaques which had existed twenty years. Microscopical examination showed the presence of typical miliary tubercles as well as the presence of tubercle bacilli and cocci.

Riehl recently exhibited a patient in whom *gommæ scrofulæusæ* and signs of internal tuberculosis had developed consecutively to the skin lesions.

Treatment: After the reconstruction of the diagnosis in this case to *tuberculosis papillomatosa cutis*, the treatment ordered was injections of iodoform in oil of vaseline. As the patient is disinclined to submit to operative procedures, the local applications are chiefly directed to the relief of the subjective sensations.

ANTHRAROBIN.<sup>1</sup>

BY

EDWARD BENNET BRONSON, M.D.

Visiting Physician, Charity Hospital.

IN the March number of the *Vierteljahresschrift für Dermatologie und Syphilis* of this year, a new remedy was introduced to the profession by the Berlin chemist, Liebermann, as a substitute for chrysarobin and pyrogallic acid. In its chemical relations the new drug closely resembled chrysarobin. As is well known it was the same distinguished chemist who first demonstrated the fact that the substance obtained from Goa powder, that is now appreciated as so potent a remedy in various epidermidoses, was not, as Attfield had erroneously supposed, chrysophanic acid, though by oxidation it could be readily converted into the latter, and to it he gave the designation by which it is now commonly known. Liebermann attributed the therapeutic effect of chrysarobin to the fact of its being a strong reducing agent. Pursuing his investigations while entertaining the above view, he has recently sought to discover other substances which, with like chemical properties, should have a similar therapeutic action. Among the substances belonging to the same chemical class as chrysophanic acid is alizarin. By a simple process of reduction he has obtained from this substance a product which he terms "anthrarobin." Like chrysarobin it is a powerful deoxydizing agent, one gramme being capable of absorbing about 120 cubic centimetres of oxygen. In appearance it is a light brownish-yellow granular powder. It is very sparingly soluble in chloroform or ether as is chrysarobin, but unlike the latter substance it is readily soluble in alcohol, and also in weak alkaline solutions. The alcoholic solution is of a deep brown color. Hot glycerine also dissolves it, and it remains in solution though it is but slightly soluble in cold glycerine. With fats it mixes readily to form ointments.

It remained to put to a practical test the theoretical claims made by its discoverer for this new drug, solely on the ground of its chemical resemblance to remedies already in successful use. The task was undertaken by Behrend, and his results are published simultaneously with those of Liebermann in an immediately succeeding article. The report of cases treated by anthra-

<sup>1</sup> Read before the Dermatological Section of the Congress of American Physicians and Surgeons, in Washington, September 18, 1888.

robin include fifteen of psoriasis, seventeen of herpes tonsurans, two of erythrasma and one of pityriasis versicolor. In all of these the success of the treatment was exceedingly satisfactory. In its efficacy the remedy seemed to occupy a middle ground between chrysarobin and pyrogallic acid, being more efficacious than the latter, but somewhat slower in its action than the former. A very noticeable fact about it was the entire absence of irritation. Most of the cases were treated either with a ten or twenty per cent. ointment made with olive oil and lard or lanolin, or with a ten or twenty per cent. tincture. In most of the cases of psoriasis, before applying the anthrarobin the patches were thoroughly rubbed with green soap, or with spiritus saponis alkalinus, which procedure was found decidedly to increase the energy of the therapeutic action. It had been stated by Liebermann that the presence of an alkali increased the reducing effect.

A few months ago a supply of this drug having been obtained I began a series of experiments. All the cases of psoriasis that came under my care at Charity Hospital during the past two or three months were treated with anthrarobin. In order better to test the comparative effect in each case, the right half of the body was treated with anthrarobin, the left half with chrysarobin. A ten per cent. ointment in vaselin was usually the preparation employed on either side, and once a day, before the applications, the patient was given an alkaline bath. Though I have notes of but eight cases of psoriasis treated in this manner, they suffice to corroborate the results obtained by Behrend. In the first five of these the effect of the anthrarobin was somewhat surprising. In all of them, by the end of the first week, the improvement on both sides was decided, but in every case it seemed as though it began a little earlier on the right (the anthrarobin side) than on the left. By the end of a month every case was apparently healed, excepting perhaps a slight patch here and there, as upon the elbows, knees or ankles. In all of them the psoriasis had been general. In one case, where the patient remained in the hospital for two or three weeks after the general manifestations had disappeared there occurred a slight recrudescence of the eruption in the form of a few guttate spots, chiefly upon the back, and they seemed to be mostly confined to the right side, looking as though the cure on this side had been less permanent than on that to which the chrysarobin had been applied. At present these spots have again disappeared under the use of

anthrarobin, together with the exhibition of arsenic internally. In the three remaining cases the improvement certainly began first on the left (the chrysarobin side), and here the progress was most rapid. In all of them the dermatitis excited by the chrysarobin was pretty decided. It is to be noted also that in these last three cases the alkaline baths which were employed in the first five were omitted with the object of avoiding some of the deep discoloration which the anthrarobin produces on the skin. As soon as the alkaline treatment was resumed the progress on the right side became much more rapid. With regard to the staining caused by the drug it is of a dark brown color, and much deeper than that produced by chrysarobin. On the other hand, it does not tend like the latter to diffuse itself over the surrounding skin. When used in the form of tincture it remains circumscribed within the area to which the application is made. Any irritation produced by the ten per cent. preparations of anthrarobin was scarcely appreciable. In one or two of the cases of psoriasis, after continued use, a slight redness was noticed over limited portions, but always so near the region inflamed by the chrysarobin as to leave it doubtful whether it was not due to an invasion of the inflammation from the left side. In some other cases, especially cases of eczema, a slight smarting sensation was produced at the first application of the remedy. That it is capable, however, of causing irritation, was abundantly shown in one case treated by a twenty per cent. ointment. It was the case of psoriasis, already referred to, in which a recrudescence of the eruption occurred, more particularly on the right side, after the patches in this region had apparently all been healed. After this stronger ointment had been continued for about a week, a diffuse dermatitis was excited, differing in no way from that produced by chrysarobin. But for this single observation I should have regarded the remedy as almost devoid of irritating properties.

Being desirous of further testing the keratoplastic virtues of anthrarobin, a number of cases of eczema were treated with this substance. All of them were subacute or chronic cases, or cases that had already been brought to a healing stage by means of other remedies. In one case of universal eczema which had been treated at first by linseed oil applications, and later with tar while the general surface still remained red, hard and pityriasic the anthrarobin was employed in the form of a ten per cent. ointment with considerable apparent benefit. During its use the desquamation and redness subsided, but a condition resembling

lichen pilaris was produced together with the production of numberless minute comedones. After several days' use it was stopped, on account of itching complained of and a return was made to tar and alkaline baths. Shortly after, the skin appeared perfectly normal, with the exception of a few irritable and excoriated patches about the legs. In a very chronic and inveterate case of eczema seborrhoicum the effect of the drug was still more marked. The disease had persisted for several years. For three years on account of it the patient had been an inmate of the hospital. It affected the scalp, both cheeks and the chest in the region of either nipple. The patches varied in appearance at different times from that of a seborrhoea sicca, or a simple keratosis to that of moist or desquamating eczema rubrum. Under various forms of treatment it had shown itself uncommonly persistent, and nothing had ever succeeded in doing more than to temporarily ameliorate the condition. After a few days' application of a ten per cent. anthrarobin tincture it was evident that a considerable change for the better had taken place. The crusts no longer formed, and the patches seemed to have diminished in extent. There were, however, some spots of moist excoriation, and fearing lest the drug might irritate too much (though there was no distinct evidence that inflammation had been excited), it was directed that for a couple of days only Lassar's paste be applied. The former treatment was then resumed in the following manner: Every second day a ten per cent. ointment of anthrarobin was applied. On the alternate days the surface was treated for fifteen minutes with oil of cade, which was then washed off and Lassar's paste applied. When last seen, a week ago, while not healed, the condition appeared very favorable to recovery.

In some four or five other cases of eczema in which the remedy was used, while it was not sufficiently relied upon to precisely test its curative effect, in no instance was there any evidence that the disease had in any way been thereby aggravated. It seemed, however, to possess little or no anti-pruritic effect. In three cases of general pruritus in old men in which it was employed experimentally, no appreciable benefit was derived. In one case in which an ulcer of the leg was slow in "skinning over," the application of a Lassar's paste containing five per cent., anthrarobin appeared at once to stimulate the process, and the sore soon healed. As to its effect on parasitic diseases I have had no personal experience.

So far as the cases thus far reported, embracing those of



Behrend and the few additional ones of my own are concerned, they seem to show that the new remedy has undoubted efficacy, both as a keratoplastic agent and as a parasiticide. As already mentioned, Liebermann anticipated for it therapeutic results corresponding to those obtained with chrysarobin and pyrogallie acid, because of the capacity which it possessed in common with these chemically allied substances for absorbing oxygen. In support of his views he states that Jarisch found that alizarin had no effect whatever upon psoriasis. With regard to chrysophanic acid the test had not been made.

Unna, who corroborates Liebermann's view with regard to the action of reducing agents upon the skin, has made some very interesting studies of topical remedies employed in skin diseases, classifying them according as they are related to oxygenation of the tissues<sup>1</sup>. He had endeavored to show that the tendency of all oxydizing agents is to a keratolytic action while that of reducing agents is keratoplastic. Conversely with regard to the derma the oxydizing agents are dermatoplastic, the reducing agents dermatolytic. The action of chrysarobin or other reducing agents in destroying vegetable parasites of the skin is ascribed directly to the abstraction from them of the oxygen necessary to their growth. Whether in psoriasis the curative effect is due solely to a process of reduction it will require more knowledge of the subject than we yet possess to determine. In this disease it is not only a deficiency of cornification that is at fault, but there is also a superabundant growth of the cells of the rete as well as a pronounced disturbance of the vascular layer. Something beside the promotion of the cornifying process would seem to be necessary to a cure of the disease. When chrysarobin is employed in this affection it is often noted that the most striking change in the progress of the cure corresponds with the development of a dermatitis. It would appear as though the inflammatory process were associated with the sudden occurrence of an inhibitory action, both upon the cellular hyperplasia and on the hyperaemia of the psoriatic patch. Whether inflammation of the surrounding skin is a necessary condition of this inhibitory action or whether the same thing is effected by anthrarobin without inflammation is a question, but certain it is that all signs of the disease are made to disappear by this agent as completely if not also as speedily as by chrysarobin.

<sup>1</sup> Ueberhäutung und Ueberhornung, *Berliner Klin. Wochenschr.*, 1883, No. 35. Also Ichthyol und Resorcin als Repräsentanten der Gruppe reduzierender Heilmittel. *Dermatologische Studien* II. Heft, 1886. Hamburg u. Leipzig.

In diseases in which the indication is purely for a keratoplastic agent, or in such conditions as obtain in late stages of eczema, where complete cornification fails to take place because of unrestored nutrition, there is reason to hope that the new remedy may render considerable service.

#### THE PROGNOSIS OF ORGANIC STRICTURE OF THE URETHRA.<sup>1</sup>

BY

E. HURRY FENWICK, F.R.C.S.,  
England.

Surgeon (out-patient) to St. Peter's Hospital for Urinary Diseases; Assistant Surgeon to the London Hospital.

**T**EXT-BOOKS of surgery, and special treatises upon stricture of the urethra, are usually silent upon the prognosis of the disease. The pathological effects of backward pressure upon the kidney, and the results of the extension of inflammation from the bladder to that organ are faithfully described as the usual outcome of unrelieved or neglected obstruction of the urethra. But no definite rules for ascertaining the progress of these insidious and hidden pressure changes are laid down, and the practitioner is left to *surmise* or to assume the stage of their development by the general condition of the patient, by an examination of the urine, or by the duration of the symptoms and narrowness of the calibre of the canal. The consequence is, that in the practical treatment of stricture we concern ourselves merely with the mechanical removal of the obstruction, and do not pause to ascertain if, or how far, the secreting structure of the kidney has been weakened, or rendered susceptible to the invasion of inflammation from contiguous surfaces.

This neglect of prognosis was brought forcibly home to my mind whilst examining the histories of 500 cases of organic strictures which had been under my care at St. Peter's Hospital for Urinary diseases during the last four years. I realized that I had no indication as to the extent of the damage which the urethral obstruction might have inflicted upon the patient's kidneys previous to his coming under my observation, nor any note to which I could refer after the completion of the treatment in order to gauge the probable improvement, nor had I, finally, in case that patient intermitted his attendance, any index to the amount of retrogression.

Now, in the obstruction offered to the overflow of urine by

<sup>1</sup> Read before the Congress of American Physicians and Surgeons, Washington, September, 1888.

the *unrelieved* stricture, three muscular systems—the vesical, ureteric, and cardiac—become successively affected with hypertrophy. This increase of expulsive power is rarely of long duration, for that stage in which the compensatory hypertrophy is insufficient to cope with the resistance is reached, and relaxation and atony supervene. The cardiac condition<sup>1</sup> is contingent upon the renal changes, which in their turn depend upon the failure of the barriers to backward pressure which healthy or hypertrophied vesico-ureteric muscles present. Hence the importance of estimating the condition of these dyke-like muscles.

Their energy or incapacity may be appreciated by ascertaining the absence or presence of residual urine, and a systematic measurement of the same at each step of the dilatation, besides affording an index to the recovery or atonicity of these muscle planes, will reckon roughly the amount of backward pressure which has already fallen upon the kidney.

I wish to lay before this Congress the results of a series of careful and systematic examinations of the residual urine in seventy-five cases of organic stricture of the urethra in order to draw attention to the important and interesting subject of the prognosis of the disease. Moreover, I would submit that just as the necessity for ascertaining the presence of residual urine in the vesical atony due to enlarged prostate or nerve-lesions is duly impressed upon the student and practitioner, so likewise ought it to be inculcated that residual urine exists in most cases of stricture of the urethra, and ought to be measured; that its removal is of value in enabling the vesico-ureteric muscles to regain power, and in preventing the establishment of chronic cystitis and calculous formation.<sup>2</sup>

The stricture cases were divided into two groups. In some the residual urine was tested at the commencement of treatment, in others at or towards the conclusion of the dilatation.

<sup>1</sup> Wishing to estimate the *ultimate* effects of unrelieved stricture upon these muscular systems, I collated the post-mortem records of the stricture cases which have been examined at the London Hospital for the last fifty years. This hospital is an unrivaled centre for the study of the worst type of stricture, for it is situated in close proximity to the shipping of the Port of London, and is placed in the heart of a large laboring population as ignorant as they are recklessly indifferent to the dangers of neglected stricture. I was struck with the frequent correspondence in the description of the pathological conditions of the muscles of the bladder and heart. Thus, "Bladder: hypertrophied and dilated; ureters: dilated and thickened; heart: hypertrophied and dilated." This is a well-known sequence in chronic renal disease of non-vesical origin.

<sup>2</sup> In 1885 I admitted a case of stricture into the London Hospital from which my colleague, Mr. Rivington, removed a calculus weighing  $1\frac{1}{2}$  lbs. (*avoldupois*) *Med.-Chir. Trans.* vol. lxi, p. 370, 1886).

*Statement.*—Residual urine was found in all the cases examined except the following five :

Initial.	Age.	Duration of stricture.	Position.	Calibre as estimated by the French gauge.	Residual urine.
F.	23	2 years	5'	10 F.	None.
W.	29	3 years	5'	17 F.	"
C.	48	4 years	7½'	Guide (4 F.)	5 minims.
R.	24	18 months	4'	10 F.	None.
B.	27	12 months	3' 1/2'	Up to 16 F.	"

From this we may argue that residual urine exists in varying proportions in ninety-three per cent. of stricture. But if the patient is young (under thirty), if his stricture is of short duration, and the calibre only about a half diminished (taking the normal size as 24 F.), then all the urine can be expelled.

I may here remark that the bladder in its normal state is capricious in the degree of its contraction. In death from cholera, and in some cases of sudden death, the bladder will be found like a uterus—hard and firmly contracted—without a drop of water in it, but even in a perfectly healthy young bladder a little urine may be occasionally found, so that I have gradually come to look upon half a drachm of residual urine as quite consistent with vesical health. I have usually found this half drachm of residual urine, not on entering the bladder but on slightly separating the folds of mucuous membrane with the point of a gum-elastic catheter, so that I have no doubt that it is a remnant which has been caught and retained between the plications of the rolled-in mucuous membrane.

Initial.	Age.	Duration.	Position.	Calibre.	Residual urine.
H.	23	1½ years	5½'	4 F. to 15 F.	1½ dr.
M.	38	3 years	Deep	Guide	1 dr.
H.	39	8 years	5'	"	2 dr.
F.	25	6 months	6½'	13 F.	½ dr.
L.	27	2 years	5½' 1/2'	15 F.	3 dr.
H.	38	5 years	3' 1/2' 1/2'	7 F.	2 dr.
C.	—	—	6½'	14 F.	2 dr.
R.	28	—	6½'	14 F.	2 dr.
O.	26	12 months	—	13 F.	1 dr.
T.	38	—	6'	4 F.	1 dr.
S.	32	4 years	2½'	19 F.	1½ dr.
B.	30	5 years	6'	14 F.	1½ dr.

Twenty-eight per cent. of the patients were found to retain only a very small amount, about one to two drachms.

It is to be remarked, however, that these patients were mostly young, and that the calibre of the canal was of fair size, for in four only was the stricture so small as to require a guide.

In a certain number (*i. e.* 60 per cent.) the amount of residual urine was large.

Initial.	Age.	Duration.	Position.	Calibre.	Residual urine.
C.	38	5 years	7"	Guide	12 oz.
O.	42	"	3"	6 F.	32 oz.
S.	—	"	5"	Guide	6½ oz.
W.	27	12 months	3½"	"	2 oz.
H.	37	18 months	4½"	"	4½ oz.
L.	36	14 years	6½"	"	1 oz. 2 dr.
H.	42	8 years	5½"	"	14½ oz.
W.	38	—	5½"	"	12 oz.
P.	39	9 years	5½"	"	½ oz.
S.	60	20 years	6"	9 F.	9½ oz.
W.	36	—	6"	Guide	7 oz.
S.	41	2 years	4½"	"	1½ oz.
		—	3½"		
H.	47	3 or 4 years	4"	13 F.	4 oz.
Ja.	32	7 years	6"	19 F.	9 oz.
E.	32	3 years	3½"	Guide	13 oz.
			2"		
R.	31	4 years	4½"	"	5 oz.
W.	34	6 years	6½"	"	2½ oz.
H.	—	7 years	6½"	8 F.	2 oz.
N.	—	3 months	7"	Guide	5½ oz.
C.	40	1 year	8½"	"	7 oz.
W.	57	33 years	4½"	"	4 oz.
			7"		
H.	45	—	4"	2 F.	2½ oz.
			5"		
S.	44	—	6"	Guide	1 oz.
S.	53	2 months ?	5½"	"	6 oz.
H.	44	6 or 7 months	6"	"	2 oz.
W.	54	13 years	—	10 F.	6 oz.

It will be seen that in this Table we have to deal with strictures of small calibre admitting only a fine bougie at the first sitting. It is to be noted that all (except one) are over the age of thirty. Thirty-two ounces is the largest amount withdrawn. More than half the cases (fifteen out of twenty-six), retain a

quantity under five oz. ; still such amounts as 32, 14½, 12, 13, 9½, 9, 7, 6½, and 6 oz. must represent a good deal of muscular relaxation.

The percentage record of the presence of residual urine in stricture of the urethra occurring in the lower middle classes in a large city may therefore be stated as follows :

In 7 per cent. residual urine was absent. In 28 per cent. only a small quantity (under three drachms) was discovered, and in 60 per cent. the amount was large, the average being 6.4 oz.

Moreover, although the length of symptoms and the narrowness of the calibre of the stricture were powerful factors in the production of atony, yet the age of the patient (*i. e.*, of the bladder) seemed the most important predisposing cause for the relaxation after hypertrophy.

*The characters of the residual urine of stricture.*—The urine has all the appearance of being excreted under pressure. It is usually clear, of light straw color, but even this varies if the amount removed be large. Thus in one case in which 28 oz. were removed, the first potful was darker than the second, and the second darker than the third (*cp.* Edelfsen [Kiel] Pflüger's 'Archiv. für Physiologie,' 'Zur Physiologie der Harn Sammlung in der Blase') Specific gravity varies from 1001 to 1005. It rarely contains albumen. Should chronic cystitis be present it is of course murky, but this is comparatively unusual.

If a record chart of the amounts withdrawn at each weekly sitting from the commencement to the completion of the dilatation be constructed, certain interesting features may be observed.

The following is the chart of a man aged 42, who had suffered from stricture for five years. The obstruction was situated at 3''; it admitted a No. 4 French bougie, and at the first sitting 32½ oz. of residual urine were withdrawn.

There are two divisions in this chart, the sudden fall denoting a prompt but partial reaccession of power, and a gradual descent indicating a tardy but ultimate recovery.

The gradual descent of the curve is noteworthy, it is broken in this instance by a secondary ascent, the reason for which will be subsequently discussed when dealing with the subject of relapse.

The most remarkable feature of the chart is, however, the line representing the sudden drop in the amount of residual urine from 32½ oz. to 14 oz. in one week.<sup>1</sup>

<sup>1</sup> This drop proves how valueless the estimation of the degree of vesical atony is, when measured by the amount of residual urine found at the first sitting.

It signified that this individual bladder had in one week regained the power of expelling 18 fluid oz. A sudden drop is a characteristic of such charts, for it is found in all cases of sudden release of tight stricture. The amount of the drop indicates

Fig. 1.

the *temporary* loss of power which the bladder had sustained. The amount noticed is often extraordinary.<sup>1</sup> The following cases will serve as an illustration.

<sup>1</sup> Author, *Pathol. Trans., Diabetes Insipidus*, vol. xxxvi, p. 801.

*Case 1.* E—, act 32, had suffered from stricture of the urethra for three years. The obstructions were situated at  $3\frac{1}{2}$ " and  $5\frac{1}{2}$ ". A filiform guide was passed with difficulty, and the constrictions dilated to 10 French calibre. The residual urine was withdrawn after micturition, it amounted to 13 oz., acid, clear. Sp. gr. 1005, no albumen. Next week only  $3\frac{1}{2}$  drachms were withdrawn, and the week after that only two drachms were found.

*Case 2.* A—, act 33. Stricture of five years' standing, situated at  $6\frac{1}{2}$ " to 7". A great difficulty with the guide. The constriction was dilated at once to 10 French; 12 oz. of residual urine were evacuated. Sp. gr. 1002. The next week only  $\frac{1}{2}$  oz. was found.

*Case 3.* J—, act 32. Stricture for seven years. Residual urine 9 oz. at first sitting, and only  $1\frac{1}{2}$  drachms the next week.

*Case 4.* H—, act 42. Stricture for eight years at  $5\frac{1}{2}$ ";  $14\frac{1}{2}$  oz. were removed the first week as residual urine, and  $6\frac{1}{2}$  oz. the next week.

*Case 5.* S—, act 35. Stricture for five years, situated at 5". Residual urine, estimated at the first sitting, amounted to  $6\frac{1}{2}$  oz. At the second (after a week's interval) only 7 drachms were withdrawn.

Initial.	Age.	Duration.	Situation.	Calibre.	Residual urine at first sitting.	Final.
C.	23	5 years	7"	4 F.	12 ounces	$\frac{1}{2}$ dr. after $2\frac{1}{2}$ months.
W.	27	1 year		4 F.	2 ounces	$\frac{3}{4}$ dr. after $1\frac{1}{2}$ months.
R.	31	4 years		4 F.	5 ounces	$\frac{3}{4}$ dr. after 9 months.
H.	47	4 years		13 F.	4 ounces	$1\frac{1}{2}$ oz. after 4 months.
H.	43	8 years	$9\frac{1}{2}$ "	4 F.	$14\frac{1}{2}$ ounces	2 oz. after $1\frac{1}{2}$ months.
O.	42	5 years	8"	6 F.	$32\frac{1}{2}$ ounces	1 oz. in 9 months.
G.	26	6 years	$6\frac{1}{2}$ "	4 F.	28 ounces.	$\frac{3}{4}$ dr. in 5 months.

As might be expected, the promptness and extent of this rapid recovery varies greatly in different bladders. So many



vital and mechanical factors have to be considered that it would be premature at present with our limited statistics to attempt to formulate it. The rough and ready rules I invariably teach are these: 1. A smart initial recovery of the vesical muscle is to be expected in every case where a narrow stricture has been suddenly enlarged. 2. The older the vesical muscle is, so much the less marked will be this recovery. 3. A smart initial recovery is no criterion to the rapidity of the ultimate recovery.

*The ultimate recovery.*—After this sudden fall it will be seen that the tracing in Fig. 1 takes many weeks in declension, that is to say, the bladder in this case, after its first access of power, regained strength, but slowly. Bladders differ widely in the length of time which elapses before they *finally* regain their strength.

Some recover quickly, others recover but indifferently both as regards time and completeness.

This fact is still further impressed upon the surgeon on examining the residual urine of patients who have been under continuous treatment for a considerable period, and in whom the quantity was not tested at the very commencement.

Thus, fairly recovered bladders were found in the following cases:

Initial.	Age.	Duration of stricture.	Treatment.	Residual urine.
H.	39	12 years	Internal urethrotomy and subsequent bougie	1 dr.
M.	34	18 years	After dilatation	2 dr.
W.	52	20 years	"	1 dr.
H.	33	7 years	"	8 min.
P.	25	7 years	"	2½ dr.
S.	32	3 years	"	2½ dr.
W.	28	3 years	"	1 dr.
J.	53	7 years	"	½ dr.
L.	34	?	"	4 min.
W.	42	?	After 2 years' dilatation	½ dr.
E.	47	25 years	After dilatation	3 dr.
B.	38	20 years	"	2 dr.
P.	22	3 years	"	½ dr.
S.	32	4 years	"	1 ½ dr.

On the other hand, the following cases were found to have more than an ounce of residual urine, although the stricture had

been fully dilated. These patients, therefore, had lost a considerable amount of vesical tone, although they had fully released urethræ.

Initial.	Age.	Duration of stricture.	Residual urine.
B.	52	5 years	1 oz.
M.	55	17 years	1½ oz.
R.	43	11 years	5½ dr.
S.	54	6 months	1 oz.
A.	53	—	4 oz.
B.	41	21 years	1 oz.

Upon what do these differences in the capacity for ultimate recovery depend? I have carefully gone into the question of retention in the expectation of finding that a single over-distension had materially weakened the bladder wall, and that repeated retention would account for the very wide differences observable in the tonicities of the bladders of stricture cases. I have been disappointed, for many of the cases which are, atonically, the worst, have not suffered from retention at all. Age of the bladder seems the most important factor. Given: Three patients at the ages of 35, 45, 55 respectively. Let each become the subject of stricture and be examined at the end of six months. It will be found that there will be a diminution of expulsive power for each decennary, and a correspondingly increased accumulation of residual urine. There are, of course, other factors which have to be remembered, and for which allowance must be made, *e.g.*, the lowered vitality of the lumbar centre from masturbation, excessive venery, abuse of alcohol, and the loss of control consequent upon cerebral or spinal lesions; but space will not allow of the consideration of their relation to the question I am now dealing with.

*Relapse.*—The vesical atony of stricture has two well-marked characteristics. Its tendency under favorable circumstances is towards recovery, and under the slightest provocation to relapse. The downward curve of the chart (*vide* Fig. 1) becomes suddenly interrupted, the amount left in the bladder after urination instead of steadily decreasing suddenly increases. Very slight causes are sufficient to effect this relapse. A cold, an unavoidable delay in relieving the bladder, a single

excess in alcohol or coition. The following may be cited as examples :

Initial.	Age.	Original amount.	Amount reached before relapse.	Relapsed to.
W.	57	10 oz.	1st relapse 5 dr. 2nd relapse 4 dr.	1 oz. 3 dr. . 2 oz.
H.	42	14½ oz.	2 oz. 1 dr.	2 oz. 4 dr.
C.	33	12 oz.	4 dr.	1½ oz.
J.	32	9 oz.	1 dr.	1 oz.
C.	28	?	6 dr.	1 oz.
S.	53	6 oz.	1 oz. 2 dr.	3 oz.

The rule may be fairly stated thus:—The larger the amount removed at the first sitting, the older the patient, the greater is the tendency to relapses.

*Precautions in measuring residual urine.*—Certain precautions are to be observed in ascertaining the amount of residual urine. They may be appropriately alluded to here for their neglect will be productive of error.

1. A blood-clot or plug of mucus, or a previously blocked catheter, will cause the practitioner to register *no* residual urine whilst a clear instrument may withdraw many ounces.

2. It is of the utmost importance, in order to secure accuracy, that the patient should hold his water for some time previous to the examination.

*If a slightly atonic bladder be partially empty when the patient starts to urinate, a great deal of the mechanical force obtained from the counter-pressure of moderate distension is lost. The ejected urine will therefore be small in quantity and the residual large.*

The following case is an example: H—, æt 45, after three months' use of a No. 12 (English gauge) steel bougie, the bladder was examined for residual urine. Nearly 3 oz. were withdrawn. At the next sitting (one week after) he volunteered the statement that he had kept his urine for four hours in order to get "a head of water on." He said he had noticed that a "fullish bladder" gave him power to expel the whole of the urine. He passed urine leaving only 8 minims behind in the bladder.

*Dangers of withdrawing residual urine.*—The dangers of removing the residual urine from bladders the subjects of atony consequent upon an enlarged prostate or upon lesions of the brain or spinal cord, have been accentuated under the term "catheter fever." I have never seen any reaction following the

removal of clear residual urine in stricture cases, and only slight malaise when the secretion was murky. Should, however, stricture and urinary paraplegia coexist the same precautions must be adopted which are observed in senile cases.

*Prognosis.*—In grasping the health of the kidneys from the indications afforded us by the examination of the residual urine, two items have to be clearly borne in mind. There is, first, the amount of pressure which the kidneys have been working against. This is to be measured by the quantity of residual urine released upon the first attempt to dilate the stricture. Without a careful comparison of the weight, size and microscopy of the *post-mortem* kidney with the amount of residual urine noticed before death, and the duration of the stricture, no formula can be constructed to indicate the amount of damage which a definite quantity of residual urine will effect upon the secreting structure of that gland. It may be safely assumed, however, that 5 oz. of residual urine which is probably near the average of unreleased narrow strictures, would indicate sufficient damage to cause anxiety as to the effects of any intercurrent inflammation or disease; while an amount over 10 oz. would make us cautious in operating for stricture by internal urethrotomy, and in giving anything but a grave prognosis of the ultimate effects of the constriction. Secondly, the behavior of the muscles in their progress towards recovery will teach us much as regards the future course of the case. The disposition to relapse, the sluggishness in recuperation would cause us to look forward with apprehension to that period of life when fatty and senile changes will step in to greatly aggravate the weakness of an organ, upon the health of which old age is mainly dependent. Lastly, we are amply justified when the initial amount of residual urine is under 5 oz., when the initial recovery is smart, and the duration of the ultimate recovery short, in giving a good prognosis, provided the full calibre of the urethra be maintained.

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### **Society Transactions.**

#### **AMERICAN DERMATOLOGICAL ASSOCIATION.**

THE Twelfth Annual meeting of the American Dermatological Association was held in Washington, D. C., on September 18, 19 and 20, 1888.

The Society was called to order by the President, Dr. J. E. Atkinson, of Baltimore, Md., who then read an

#### **ADDRESS**

in which was passed in review the work of the past year and a retrospect

taken of the advances which dermatological science has of late made. By the process of suppuration the speaker illustrated how apparently dissimilar morbid actions may have a common origin, and how identical results may follow the action of dissimilar causes. According to the place of its activity the results produced by a morbid agent vary greatly.

Thus impetigo, furunculosis and sycosis are found to be due to the invasion of the staphylococcus, and the difference in results noted is due to the difference in depth to which the micro-organisms penetrate. On the other hand we find the two diseases rubeola and rubella to be almost identical in appearance, yet produced by morbid principles which we have every reason to believe are unrelated. Pathogenesis is regarded by the speaker as the essential thing in medicine and etiology, as the soul of pathology. He believes that we are now forced to regard simply as skin diseases, many conditions whose etiology is not understood and which are in reality but the outward expressions of pathological processes subtle and remote. Among instances of such affections the author thinks we must include dermatitis herpetiformis, as well as various forms of dermatitis exfoliativa and of pemphigus.

In dermatitis herpetiformis we find that the pathological changes vary, and the symptoms are so different in character in different cases that we can scarcely believe the eruption to have a constant and characteristic etiological relation to any defined morbid process.

In the same way with impetigo herpetiformis. If it be shown to originate in one of several morbid conditions acting upon the trophic centres, and producing the skin eruption as a secondary effect, we should not regard it as a special disease.

In the absence of an exact knowledge of many pathological processes and etiological influences we are forced to consider many of these skin eruption more in the light of what they seem to be than what they really are.

The speaker referred to the influence which bacteriological research had exerted upon recent progress in dermatology and hoped that the study of other branches would equal it in results.

Dr. G. H. ROSE, of Baltimore, read the first paper which was entitled

#### THE ELECTROLYTIC DECOMPOSITION OF ORGANIC TISSUES.

After reviewing at some length the field of electrolysis the author said that in the extirpation of superfluous hairs the electrolytic action is most frequently made use of by the dermatologist. Here we have normal tissue to act upon and a tissue quite resistant to external impressions and readily regenerated. Strong currents are needed because the tissues have normal, chemical and vital stability, and the papilla of the hair must be destroyed. The electrolytic action probably continues after the operation, but little effect is attributed to this fact. New growths require for their destruction less strength of current. Fibro pigmentary growths are usually very resistant to electrolytic destruction and require strong currents and thorough application to the whole affected surface.

In stricture of the urethra the only way to effect a cure is to cause absorption of the submucous inflammatory deposit. No method promises theoretically to accomplish this so safely, promptly and thoroughly as electrolysis, and this method seems the one most rationally indicated to the

author. The current promotes absorption by causing chemical resolution of the inflammatory infiltration.

In the discussion DR. HEITZMANN said he had used electrolysis in the treatment of keloid without, however, obtaining very favorable results.

Althaus, who first advocated the method for keloid has now given it up.

DR. MORISON had found hypertrophic scars much benefited; the superficial vessels were cut off, the tissue was rendered white and the growth flattened. In keloid, too, he had had good results in one case.

DR. FOX did not favor electrolysis for keloid. He had treated five true keloids by this means, but the results were not permanent, and the only real benefit came from the obliteration of the superficial veins.

DR. HEITZMANN, of New York read a paper upon

#### THE VALUE OF SALICYLIC ACID IN DERMATOLOGY

in which he gave the results of several years' employment of the drug in a great variety of skin affections.

He had found it to possess advantages over chrysarobin, and tarry preparations for the treatment of some diseases without having their disadvantages, and furthermore for dispensary practice, it had the advantage of being cheap. The important point to be observed in using salicylic acid was to obtain a pure preparation. Unless of the best quality the drug does not act so well. The characteristic feature of the action of the remedy is its effect upon the epithelial structures of the skin and hypertrophic conditions of these structures. In callosities, corns, warts, and in fact in any thickening of the epithelium its beneficial action may be seen. No other agent softens and destroys these tissues so well, if we except acetic acid. The author also regards this drug as a valuable parasiticide, and one not yet fully appreciated. Twenty-four varieties of skin diseases were treated in the observations made, and the drug was used either in the form of a powder; as a plaster; as an ointment or in solution.

If used as a solution it should be one in alcohol from which a watery solution of any desirable strength can be afterward made.

The author has found excellent results to follow its use in hyperidrosis whether of the feet, hands, axillæ or other regions. His experience had been limited in seborrhœa alone, but when seborrhœa and acne existed together, its application was attended with brilliant results. He had found one per cent. of salicylic and six to eight per cent. of sulphur, a combination which in seborrhœa of the scalp did excellently, and was much preferable to tar in treating fastidious patients.

The parasitic action of the drug is seen in the cure of furuncle, and the author says that this is the only drug he knows of which in the cure of this disease acts by destroying the cause. In one case of dermatitis herpetiformis salicylic acid proved to be the best remedy which the patient had employed.

In psoriasis it was found very useful, and in lichen planus its superiority over Unna's sublimate salve was noted. The percentage of the solution must be high, a three to four per cent. lotion being necessary in some cases to destroy the lesions.

Eighty-six cases of eczema, in all its varieties, are recorded, and the results were favorable. To begin with in eczema madidans and eczema

pustulosum a one-half per cent. solution was employed. In infiltrated patches six to ten per cent. plasters or mulls were used. Chronic isolated patches of infiltrated skin, attended with great itching, will have the epidermic scales softened by applying a ten per cent. plaster at once. The rete mucosum is not much affected by the acid.

A three per cent. alcoholic solution diluted to a one-half per cent. solution to begin with will assist in softening the comedones and hasten their removal in acne. In acne rosacea favorable results are reported, but not in sycosis. Here the salicylic does not penetrate to the roots of the hairs and the pustules about them are not readily affected by the drug. Salicylic acid powder applied directly to a corn and maintained *in situ* will remove the growth in eight to ten days. The corn returns if the pit is left, but this may be cut out with curved scissors. In rosacea hypertrophica it is equal to sulphur lotions. Brilliant results were noted at first when ten to fifteen per cent. mulls were applied as a germicide to lupus erythematosus. Though there was no cure, there was great improvement. The penetrating power is not sufficient. In pruritus, especially of the extremities, a half per cent. solution did good, and obstinate pruritus was cured. In *tinea trichophytina* the author prefers mercurial plaster, but in *tinea circinata* and *tonsurans* he highly recommends it and regards it as superior to the four per cent. sublimate solution in myrrh recommended by Dr. Taylor. He says as *tinea tonsurans* is obstinate it is well to have a variety of remedies. In *tinea versicolor* he has found that Vlemingx's solution cures so quickly that he has not tried the salicylic.

In discussing the paper, DR. PYE SMITH, of London, Eng., said he had had excellent results in removing epidermic accumulations, and hypertrophic growths of the hands, etc. In ichthyosis he had obtained only temporary benefit, but in lichen planus the drug acted well. After speaking of other personal experience with salicylic acid, Dr. Smith spoke in the most complimentary manner of American work in dermatology and the recognition it was receiving from his own countrymen.

DR. BULKLEY had used the drug extensively. It was a great boon to those who suffer from hyperidrosis and bromidrosis. In eczema care must be exercised as inflammation is readily started up under its influence. In favus the salicylic is a valuable remedy to apply to the scalp in the form of an oily solution after epilation has been practiced.

DR. FOX had used salicylic to a large extent, and has found it of value especially in eczemas in about a two per cent. strength. He had used it in castor oil, which is the only fixed oil in which it is readily soluble.

DR. VAN HARLINGEN regarded salicylic acid as an antiseptic and a solvent of hypertrophied epidermis. One practical lesson he had learned, and was constantly putting into practice in his dispensary work. He applies to eczema of the leg a paste made with salicylic acid, oxide of zinc and glycerine and over this a moist two-tailed bandage from the toes to the knee, and leaves it on constantly from three days to a week and finds it much superior to other methods.

DR. BRONSON thought there were limitations to the drug as a therapeutic agent. In most cases he uses it as a preparatory dressing to other lines of treatment. Thus in pityriasis and seborrhoea sicca, with accumulations of dead epithelial scales, it removes the debris. He thought the reader of the paper in error when he attributes to Unna the belief that in salicylic acid we have a keratoplastic agent. The only cases in which the drug is curative are those in which it exerts its germicidal properties.

## ANTHRAROBIN.

DR. E. B. BRONSON of New York read a paper upon the use of

ANTHRAROBIN IN DERMATOLOGY.<sup>1</sup>

In the discussion of Dr. Bronson's paper Dr. Heitzmann did not think there were advantages in the new drug which should cause it to replace chrysarobin since it had itself some disadvantages.

DR. MORROW had observed the action of anthrarobin in several cases at Charity Hospital and its action had seemed to him not as efficient as that of chrysarobin, still he thought it might find a field of usefulness in cases where chrysarobin was not tolerated.

DR. J. E. GRAHAM, of Toronto, Canada, read the next paper entitled

## A REPORT OF FOUR CASES OF DERMATITIS HERPETIFORMIS.

One of the cases reported was that of a young woman who, as a child, had suffered from vesicular and bullous eruptions. Three days after the birth of her second child an eruption of a bullous character suddenly developed. Two of the lesions were located at the corner of either eye and other lesions subsequently appeared upon other portions of the face; some were as large as a ten cent piece and others as large as a silver quarter. They extended from their borders. In this case death took place a month after she came under the author's observation.

The other case occurred in males and corresponded closely to the description of the disease as given by Duhring.

DR. H. W. STELWAGON, of Philadelphia, Pa., followed with a paper upon the same subject:

## DERMATITIS HERPETIFORMIS, WITH NOTES OF THREE CASES.

The author had only observed three cases of Duhring's dermatitis out of a total of 8,000 cases recorded. Two of the cases reported are typical examples of dermatitis herpetiformis of the vesicular variety. The third was one of multiform lesions, at one time looking like a pemphigus, at another like herpes iris and again closely simulating erythema multiforme. This patient had passed from observation and gone to New York.

The second case had been under the author's observation for eleven months. It could not be regarded as a pemphigus, for at times the symptoms resembled those of dermatitis herpetiformis. It might have been classified under the designation of Hydroa of Tilbury Fox. Hydroa herpetiforme is an indefinite term but evidently describes a similar condition to dermatitis herpetiformis. These two papers were discussed together.

DR. HYDE said we must have a history of eruptive outbreaks extending over a considerable time to warrant the diagnosis. Impetigo herpetiformis and pemphigus foliaceus must not be confounded with those described in the papers. Dr. Graham's third case did not show the lengthy history of eruptions. A case was mentioned quite similar to one of Dr. Graham's, in which exfoliation of the skin had followed an eruption of blebs, vesicles and pustules.

DR. BULKLEY mentioned a case under his care in which the eruption had lasted for a year. After the patient's death, six months later, diffuse sarcoma of the internal organs was found. The eruption had seemed to him to be due to trophic disturbance. Another typical case like those of the readers of the papers died about a month ago of acute congestion of the

<sup>1</sup> Page 409.



brain. He desired to protest against including impetigo herpetiformis under this disease.

DR. FOX said his faith had been shaken in the identity of all the conditions included under the term dermatitis herpetiformis.

DR. STELWAGON's case which had subsequently come under his care, illustrated how a disease may in its varied phases appear as one thing at one time and something quite different at another. This case when first seen was simply erythematous. If there were such a term as chronic erythema multiforme it might have been applied to this condition. There was a recrudescence of erythematous patches, and bullæ appeared at times upon the tongue. No treatment prevented a return.

DR. HEITZMANN had some twelve years ago described impetigo herpetiformis in a woman who was not in the puerperal state. Kaposi had since described a case in a man though previously claiming that it was confined solely to puerperal women. He did not think this disease should be included in dermatitis herpetiformis. He had recently seen a case with his son, Dr. L. Heitzmann, which at first was taken for a pemphigus, but which they agreed was a typical case of Duhring's disease. He cannot understand why so many of the cases prove fatal.

DR. SHERWELL called the attention of the Association to the discovery he had made in several typical cases of the existence of diabetes. Under treatment directed against the latter disease the eruptions improved. The examination of the urine he thought should never be overlooked.

DR. GRAHAM said that he had found the urine of high specific gravity, but there was no sugar or albumen present in his cases. He had regarded his third case as one of pemphigus and it is one as some authors describe the disease, but it comes within Duhring's description of dermatitis herpetiformis. Pityriasis rubra and pemphigus are similar to these cases. We must study the etiology and, as the President had remarked, the conditions may arise from different causes.

DR. STELWAGON said that no matter what the cause may be, we classify skin eruptions according to the lesions present and not from the etiology, the source of irritation may vary, we must place these cases under dermatitis herpetiformis, pemphigus or hydroa. He thought the new name covers these various conditions very well.

DR. ATKINSON did not favor a multiplicity of names and recognized a strong pathologic chain binding together these different diseases.

We have a classification according to the pathological expression present, but an etiological classification should be aimed at. Thus herpes facialis is not given as the diagnosis when croupous pneumonia is known to be present and the cause of the eruption. The lesions in these cases may be secondary to changes in trophic centres, but we must strive to find out what these changes are.

DR. ROBINSON said that there was a limitation to classification from an etiological standpoint. Take acne for example ; in one case one would have to classify it as due to stomach irritation and in another to irritation of the genital organs.

DR. A. VANHARLINGEN, of Philadelphia, Pa., read a

#### NOTE OF A CASE OF FILARIA MEDINENSIS.

The disease had existed upon the palm of a male patient and was illustrated by a colored drawing.

#### SKIN DISEASES IN THE NEGRO.

This subject was treated of in a very interesting paper by Dr. R. B. Morison of Baltimore. For several years the reader had preserved histories

and notes of the cases of skin diseases in the negro which differed from the same disease in the white race, and had been able to tabulate 500 cases in which histories had been kept, out of the large number of negro patients he is constantly seeing in public practice. These tables show that acne is uncommon and likewise lesions due to prediuli and insect bites. Ainhum is peculiar to the race and two cases were seen. One man had lost one little toe, and that of the opposite foot was affected. Chancre is more indurated and more frequently complicated by phimosis; chloasma appeared to show a lessening of pigment instead of an increase.

Chilblain is common. Elephantiasis arabum mostly follows syphilis. Erythema multiforme is naturally difficult to diagnose as are all erythematous conditions.

Eczema appears to be more amenable to treatment than in the white; 129 cases are recorded.

Favus is rare and it is thought the custom of keeping children's hair short may account for the rarity of this as well as of pediculi capitis.

Keloid appears common, especially false keloid, after injuries. It is seen following variola and zoster, after piercing the ears. Lupus is seldom encountered. Two cases are given both in women. Lymphadenitis is quite common; pruritus is much complained of and it is said that syphilitic lesions itch in this race.

Scabies was rarely seen.

Syphilis is abundant.

Scaly and pustular lesions are often seen.

Urticaria wheals do not seem to be so elevated, but very itchy. The negro seems to be free from the annoyance of mosquito bites. The cimex lectularius has no terrors for him, and the bites of insects do not appear to produce the same ill effects upon the black as upon the white skin.

In discussing this paper the President, DR. ATKINSON, congratulated the reader on bringing this subject to the attention of the Society, as a chapter on skin affections, as occurring in the negro was very desirable. He himself had seen several thousand cases of skin affection in the negro. He agreed with the statement that acne was uncommon, but wished to call attention to a pustular folliculitis, very frequent in young closely shaven negroes. The pustules penetrate into the follicles of the beard, without producing that degree of irritation which is to be called sycosis. This condition is rare in the white man, but he thought fifty per cent. of young negroes who shave very close had it, they seldom applied for treatment. Periaidenitis in which the gland became lost in great masses of inflammatory tissue was frequently seen. Pus formed in pockets and had a serous or watery appearance.

Chloasma he thought extremely common in impure breeds, and in the light colored negro. After the application of a mustard plaster it is common to find deep and permanent pigmentation. In relation to the statement regarding acute and chronic eczema, his experience could not bear out that of the reader.

False or traumatic keloid was extremely common. He had seen ears affected after injury from earrings, the new formation making masses which would weigh a pound or more. In other regions the same is noted, as in scars upon the chest, after vaccination, and more especially after burns when it is almost certain to occur. Involution takes place after a time and the keloidal tissue becomes flacid and after some years, soft. As regards pediculi he had not observed any fewer cases in the black than in the white, especially among children. He thought them as frequently affected with pediculi capitis as were white children. Pruritus he had found very common, but

regarded it as due to bed bug bites which seemed at times to produce extreme itching. Scabies, contrary to the writers experience, he had found quite common though the characteristic lesions were difficult to make out.

He could confirm the statement that itching is complained of during the eruption of secondary syphilis. Pustular lesions are much more common than among the whites. It may be due to what we call "scrofula" being more frequently seen among negroes. Circinate papular syphiloderma which begins as lenticular papules, flattening and becoming depressed in the centre, and forming iris like arrangements, and circles forming one within another, was sometimes seen in negroes of mixed descent.

Vitiligo produced a marked contrast, and was noticeable in this race, but he thought it not more common than in the whites. Acute exanthemata, as Dr. Fox had said, produced upon desquamating a peppered appearance. He had called attention to this fact in his article in (*Reference Handbook of Medical Sciences*). He had described it as looking as though the skin were dusty or sprinkled with fine powder. It is due to the slight elevation of the scarlatina papules, which is not evident in Caucasians.

DR. HEITZMANN said in chloasma there was an hypertrophy of pigment and asked how if there was here a diminution of it, this term was applied.

DR. BULKLEY regarded vitiligo as rather common in negroes. In chloasma he had found the patches darkened.

DR. FOX spoke of the difficulties of early diagnosis of scarlatina. The throat symptoms and fever course having to be relied upon. At the time of desquamation the peppery skin is remarkable.

DR. MORISON said he had called the pigmentary disease chloasma, because he considered it due to uterine disturbances, and the spots were not light enough to class as vitiligo.

DR. H. W. STELWAGON, of Philadelphia, read a paper on

#### MOLLUSCUM-CONTAGIOSUM, A PRELIMINARY REPORT<sup>1</sup>

##### NOTE RELATIVE TO THE TUBERCULAR LESIONS INDUCED BY THE INGESTION OF THE IODINE COMPOUNDS.

This was the title of a paper read by Dr. J. N. HYDE. The first case reported was that of a young woman seen in a Chicago hospital who, took three times a day, teaspoonful doses of a solution containing one grain of iodine and one drachm of the iodide of potassium. On the third day a number of semi-solid papules appeared on the forehead and two or three on the dorsum of the hands. There was a moderate coryza. The entire scalp became soon covered with the same lesions which rapidly increased in size and spread upon the neck and between the scapulae behind, as well as upon the forearms and hands. The drug had been continued and the cutaneous lesions became constantly aggravated until the girl's appearance was very repulsive. Matted hair projected between the large tubercles upon the scalp. The tubercles were of a dull reddish hue and projected prominently from the surface and macerated and fissured upon their flattened summits.

Many of the lesions resembled secreting or vegetative condylomata. None were true bullae and when punctured did not extrude their contents. They were evidently masses of softish vascularized epithelium secreting a grumous mucoid fluid. The other portions of the body were free. The general health was not affected to any degree. The iodide was stopped as soon as Dr. Hyde saw the case and prompt disappearance of the lesions followed. An oil painting of the patient as she then appeared was shown. Dull red infiltrations

<sup>1</sup> Will be published in a subsequent number of this JOURNAL.

were left as the disease subsided and superficial ulcers formed upon the back. Two weeks later the drug was administered in the same dose and the same eruption promptly appeared.

The author's second case was that of a male infant of seven months, previously healthy; a crust upon the scalp had been treated with iodide of potassium; and the present eruption had gradually appeared and extended until the scalp, face, ears, neck and fore arms became the seat of an almost confluent eruption of dark semi-solid tubercles. Little disturbance of the child's health was apparent. Upon its discontinuance the lesions subsided immediately. These cases, together with three previously reported by the reader and two reported by the late Tilbury Fox and T. C. Fox, all appear to belong to the class of non-bullous iodide eruptions.

Morrow's remarkable case was that of a moribund patient presenting strictly bullous lesions, and belongs to another class. Attention is called to the fact that the regions invaded are almost exclusively the scalp, neck, chest, forearm and hand.

DR. HEITZMANN had seen a case where small doses of the iodide had produced a bullous eruption. In another case large doses of bromide produced tubercles which ulcerated and purplish granulations grew from the base. He thought these drugs formed an exit through the sebaceous glands and thus irritated the skin.

DR. MORISON had found that permanganate of potash in one grain doses cause acne, which after being cured, reappears and also produced bullous lesions.

DR. MORROW had seen vegetative lesions, as a secondary result of bullous eruptions upon the backs of the hands. The papillomatous feature was so developed that the lesions were regarded by dermatologists to whom he had shown the case, as those of lupus verrucosus, but they disappeared within a short time. He commented upon the singular fact that in all of these cases the eruptive elements are confined to the face, hands and fore-arms. In many cases the patients died of cardiac or renal trouble soon after. He does not believe with Heitzmann that the drug is eliminated through the glands, since the most careful examination fails to detect any trace of the drug in the contents of the lesions.

DR. STELWAGON related a case in which small vesicles which spread and involved the deeper portions of the skin had been noted. The patient shortly after died of cardiac disease.

DR. ATKINSON referred to a case in which ulcerations supposed to be of malignant nature were present and an eruption like keloid or a compound folliculitis. The iodide was stopped and the recovery was rapid.

DR. R. W. TAYLOR read a paper upon

#### SO-CALLED "ACNE ANTHRACOIDE IODOPOTASSIQUE."

Dermatitis tuberosa, as the author calls this manifestation of the toxic effect of iodine preparations, is a very rare condition.

This form of eruption was first brought to notice by Besnier, of Paris, and named by him *acne anthracoides*.

The reader endeavored to show in his paper that a correlation exists between all forms of iodic eruption; that instead of their being many varieties of iodine efflorescence there is really but one eruption which shows itself in various forms and passes through various transformations. In Besnier's case veritable tumors appeared upon a man's face and thorax, after taking

the iodide for a week. They were of a coppery-red color, flabby and showed depressions like anthrax.

Duhring had described a "circumscribed phlegmonous dermatitis," following moderate doses of the drug for some weeks, which simulated an irritated patch of ring worm. The case the reader reported was one of a man, set 26, who after taking twenty-five grains of the iodide of potassium for twelve days, increased the dose to forty grains and within fifteen hours thereafter began to show signs of the cutaneous effect of the drug. Its use was persisted in, however, until sixty and then eighty grains were taken thrice daily. Tumors occurred upon the forehead, temple, right cheek and upon the left side of the face and neck. The color was deep red, some were oval in shape, and the size varied from a three cent piece to a quarter of a dollar. They were both pedunculated and sessile. That upon the temporal region presented the shape of a mushroom. Its surface was covered with minute deep yellow crusts. Some of the lesions reached an elevation of nearly half an inch. Small cribriform openings upon the surface of the lesions lead to minute abscess cavities in their body.

These tumors begin as localized congestive swellings of the skin. The sebaceous follicles become involved, and evidences are present of exudation and cell infiltration into the papilla cutis, which is the natural outcome of the inflammatory process. The author believes that iodic eruptions are correctly and simply divided into two classes; the hemorrhagic and the dermal inflammatory. In most cases the essential lesion is the dermatitis. Vegetating and fungating features have only led observers to incorrectly make new and separate forms. The term dermatitis tuberosa is considered preferable to that suggested by Besnier. Bullous forms he believes are due to tissue peculiarities, and the subsequent warty surfaces to the intensity and persistence of inflammation.

In the discussion

DR. HEITZMANN thought the condition in Dr. Taylor's case was the same which Dr. Hyde had described in his paper. He asked for Dr. Taylor's idea of the mechanism by which the poison acted.

DR. TAYLOR answered that it was an angio-neurotic influence transmitted to the blood vessels through the nerves.

DR. ROBINSON thought that the term dermatitis does not mean anything and that we should not use it unless we understand the etiology. He did not regard the term dermatitis tuberosa as a good one.

DR. HYDE said the views of the reader accorded with his own regarding etiology. In cases of iodic purpura which he had seen, there was a marked tendency to localization upon the lower extremities, and he had never seen it upon the upper.

DR. MORROW said that in many cases of iodic purpura there was an eruption upon the upper extremities and he himself had seen it upon the arms.

It seemed possible to conclude that the influence of the syphilitic virus upon the blood vessels may have some agency as a determining cause.

He had seen the bromide produce such lesions as Dr. Taylor described with an anthracoid appearance. He believes that it is within the sphere of the nervous system that we must look for an explanation of the mechanism of the eruption.

DR. ATKINSON said the case was similar to the one he had referred to the day before. He regarded it as eminently a folliculitis, the formation was so evidently follicular. He considered it due to an irritation in the follicles of the iodine compounds.

DR. MORROW, of New York, read a paper entitled  
 CASE OF TUBERCULOSIS PAPILLOMATOSA CUTIS WITH REMARKS ON THE  
 RELATION OF PAPILLOMA TO SYPHILIS, LUPUS, ETC.<sup>1</sup>

Three papers on the subject of Lichen were read, one by DR. FOX, of New York, upon

THE NON-IDENTITY OF LICHEN PLANUS AND LICHEN RUBER

in which he maintained that the diseases could not be considered as one and the same. Five cases of lichen ruber were reported to confirm this view.

The chief points in the cases were as follows: Two of them had been shown at the New York Dermatological Society, one having been sent to him by Dr. Sherwell, another by Dr. McMaster. Two were boys. The fifth was a young man in which the monileform lesions were well marked upon the anterior aspects of the arms and bends of the elbows. Attention was called to the resemblance two of these cases bore to lichen psoriasis vel lichen ruber described by Jonathan Hutchinson. In most of these cases the disease showed a marked tendency to grow better and worse at times, and during the relapses a general acute exfoliative dermatitis occurred in the cases of the two boys, lasting for a few weeks. In none of the cases was there any resemblance to lichen planus either in form, color or distribution of the lesions and much less in the natural course and termination of the disease. Of the five cases two are now dead, and in two now under the reader's observation the prognosis is grave although the patients enjoy a fair degree of health and at times suffers very little from the affection.

Dr. ROBINSON's paper had for title,

THE QUESTION OF RELATIONSHIP BETWEEN LICHEN RUBER (HEBRA), AND  
 LICHEN PLANUS (WILSON).

As in the foregoing paper the writer makes a strong argument in support of the opinion generally held in America that in lichen ruber and lichen planus we have distinct diseases to deal with.

The writer compares the clinical symptoms, histology, prognosis and results of treatment of these two forms of eruption, as described by Wilson and Hebra, respectively, and, after carefully weighing the evidence, concludes that the diseases are decidedly distinct. Too much weight must not be placed upon the appearance of the primary lesions. Red, scaly papules alone are not characteristic of lichen ruber. An acute form of lichen ruber has been described by Unna, but the eruption in his cases bears so little resemblance to the descriptions by Hebra that unless such cases were left untreated and watched, so as to observe if they assumed later on the characters of chronic lichen ruber, the writer does not think they should be accepted as examples of the disease.

It has been argued that the anatomical situation of the lesions would account for the differences in appearance of the two forms of eruption, but if we study the appearance of a patch of lichen planus, which has invaded hair follicles and note the absence of scales in many cases, or study the two diseases, as they affect the palms, this view has no foundation.

In conclusion, Dr. Robinson claims:

1. That lichen planus and lichen ruber are in doubtful cases, especially

<sup>1</sup> Pages 360 and 401.

to be diagnosed, not from the form of lesion alone, but also by the whole symptoms and course of the eruption.

2. That lesions resembling those of lichen ruber and lichen planus exist in other diseases.

3. That the cases reported by Unna were not instances of the lichen ruber of Hebra.

4. That the same is true of Boeck's cases.

5. That no cases have been reported which show absolutely, or even with probability, that lichen planus and lichen ruber are but two forms of the same disease.

6. If an identity of etiology existed such cases would long ago have been reported, since lichen planus is a rather frequent disease.

7. In the absence of proof of combination or transformation of lesions, and because of the differences in symptoms, course, prognosis, histology and effect of drugs, in the two forms, we find no grounds for considering them identical diseases.

The title of DR. TAYLOR'S paper was

#### LICHEN RUBER AS OBSERVED IN AMERICA AND ITS DIFFERENTIATION FROM LICHEN PLANUS.

The writer made a strong argument to oppose the views upon this question entertained abroad and by a few dermatologists in this country. Many convincing illustrations of cases were shown and a report was made of two characteristic cases of lichen ruber under the writer's care. A table of differential diagnosis is attached to the paper, the result of sixty-four personal recorded cases of lichen planus.

Under no circumstances should the one disease be mistaken for the other by a trained clinician, excepting, perhaps in one stage of lichen ruber, which, however, is a short one. That is when the papules are fully developed, numerous, and distinctly clustered, in groups. (Second stage).

He divides lichen ruber into three stages :—

1. Stage of isolation of the papules.
2. Stage of coalescence of the papules.
3. Resulting chronic infiltrated, pigmented and scaly stage.

Particular attention is called to the condition of the nails, which are dull white or dirty yellow, rough, serrated, and, at least, four times their normal thickness, while lichen ruber has no nail changes.

In the discussion of these three papers there was a unanimous opinion that lichen ruber and lichen planus are two separate and distinct diseases.

DR. SHERWELL had seen a few typical cases of lichen ruber, and while in it marasmus leads to death, in the other disease, lichen planus, the general health is not profoundly affected.

DR. BRONSON had been for a long time a firm believer in the non-identity of the affections and thought that the way in which the subject had been treated in the papers read would go a long way toward a final settlement of the question.

DR. BULKLEY said no one had ever seen the one affection develop upon or from the other, and this he regarded as one of the strongest arguments against their identity.

DR. HEITZMANN thought that Hebra had called these cases of lichen

planus in the early times chronic eczema. He is convinced that the disease differs from lichen ruber.

DR. ROBINSON said that he had omitted to read that portion of his paper which treated of the pathological anatomy. The distinction between the two diseases was evident from the clinical history and the results of treatment alone. Even should a case of lichen ruber develop upon a patient who had lichen planus he could not consider it as proving the identity. [He had been unable to effect a cure in lichen planus with arsenic, but had cured some cases with colchicum and the iodide of potassium within a short time.

DR. TAYLOR did not believe that the two diseases were in any way interchangeable. The case of lichen ruber which was at the present time under his care was a typical one. In two previous attacks of eruption, from which she recovered, the nails have been shed. The prognosis so far as the present attack is concerned is good.

DR. BULKLEY of New York then read a paper entitled

#### DERMATITIS PALMARIS ET PLANTARIS.

The writer differentiated this disease from psoriasis, dysidrosis or cheiro-pompholix, lichen planus, and erythema palmaris. The distinction between the chronic stage of this dermatitis and the conditions called by some psoriasis, xeroderma, scleroderma, callositas and tylosis palmaris, is more difficult. Dermatitis palmaris et plantaris was described as an acute or chronic inflammation of the parts apparently idiopathic in nature and not due to the action of external agencies so far as can be observed.

Case I. was a young man of twenty-three, who had between the age of eleven and fourteen had several attacks of peeling of the hands. At the age of twenty-one he had four attacks at intervals of a few weeks, and a single attack each of the next two years.

The hands would become hot, swollen, stiff and dry, purplish and tender.

The soles would become affected about a week later. There were never any papules, vesicles or moisture present. With the more severe attacks he occasionally noticed a slight rash over the abdomen, or even more generally, which scaled to a moderate degree, but in a large share of the attacks, only the palms and soles were affected and always severely, large masses of epidermis peeling off readily.

The other two cases reported were similar, excepting that they showed no rash on other parts, and although still others had been observed, these serve to illustrate that the disease is distinct from other commonly known affections. Sudden occurrence of inflammatory symptoms have characterized the attacks. A definite and more or less self-limited course is run, complete exfoliation of the epidermis without the production of any separate lesions. In two cases it was recurrent and in a third persistent.

It would seem probable, that the cause must be looked for in the nervous system. Both internal and external measures are to be employed. Internal, directed toward the neurotic element. Locally emollients and, subsequently, borax and glycerine in rose water hastened cornification.

DR. HEITZMANN asked if there had been an increase of hair upon the backs of the hands.

He had recently had such a case in which this feature was marked, the



palms had exfoliated since childhood, there was, however, moisture of the palms in his case. He had named it dermatitis exfoliativa.

DR. HYDE had seen the whole epidermis of the palm exfoliate at once, forming a cast. Last year he had read a paper with the same title as that of Dr. Bulkley's paper, describing similar recurrent disorders. In his cases he had noted marked changes in the hairy growth at times. He thought the condition due to central nerve trouble.

DR. BROWSON agreed with Dr. Bulkely that there is met with a form of inflammation of the palms and soles which is peculiar, and thought that the term used was a good one.

DR. C. HEITZMANN, of New York, then read a paper upon

#### KRAUROSIS OF THE VULVA (BREISKY).

Kraurosis of the Vulva is, the reader said, a disease which Breisky describes in his work on gynecology, as a peculiar affection upon the vulva which he regards as an incurable one. Dr. Robert Weir, of New York, some fourteen years ago described the same disease under the name of ichthyosis of the vulva. No reference to the disease is found in text books of dermatology. It is a chronic eczema characterized by the presence of sharply circumscribed patches, in a slight degree milky and almost psoriatic in nature when the disease is in a high degree of development. To the touch the patches prove to be thickened epithellum with subjacent infiltrated connective tissue. There is no marked papillary structure. Accompanying this there is always a severe catarrhal vaginitis recognizable, with muco-purulent discharge and attended with severe tormenting itching. In consequence of this trouble all the patients are melancholic, sleepless and despondent. Four cases have been seen by the speaker. The youngest a virgin of thirty-five, the others fifty or sixty years of age. In every case the disease had lasted for several years. It is not improbable that the discharge causes the eczema, for in all cases after a cure was obtained the vaginitis had considerably improved. The urine showed a heavy sediment of uric acid in one case and of oxalate of lime in the other. In both the specific gravity was over 1,080. No albumen or sugar.

The author has succeeded in curing every case by removing the thickened patches with the sharp spoon under a twenty per cent. solution of cocaine applied to the parts as a local anæsthetic. This was followed by the continuous application of from a one half to a two per cent. solution of salicylic acid alternating with pyrogallol solution in same strength.

Should small nodular thickenings remain they may be removed with nitric acid applied with a sharply pointed box-wood rod or knitting needle. The disease is prone to return and repeated applications may in some cases be required.

This disease is a rather serious one, both on account of the mental disturbance it causes, and the danger of epithelioma growing upon the infiltrated portion, as was the case in Dr. Weir's patient.

The following officers were elected for the ensuing year :

PRESIDENT—Dr. J. E. Graham, of Toronto, Canada.

VICE-PRESIDENT—Dr. Samuel Sherwell, of Brooklyn, New York.

SECRETARY AND TREASURER—Dr. G. H. Tilden, of Boston, Mass.

## Book Review.

### GONORRHOEA OF THE SEXUAL ORGANS AND ITS COMPLICATIONS.

According to the Newest Scientific Standpoint and Numerous Personal Studies and Researches. By DR. ERNEST FINGER, Docent in the University of Vienna. 318 pages in 8vo., with numerous woodcuts and five colored plates. Franz Deuticke, Leipzig and Vienna, 1888.

IN the first twenty pages of this well-written treatise the author reviews the history and treats of the etiology of gonorrhœa. Regarding Neisser's gonococcus as the proved and recognized cause of this disease, he gives in detail its bacteriological and microscopical characters and shows that it is in reality a diplococcus, its two halves fitting to each other much like the parts of a coffee bean.

In the second part of the work devoted to the special forms of the disease the author enters extensively into the description. First, of gonorrhœa in the male; second, of gonorrhœa in the female; and third, of the complications of gonorrhœa in both sexes.

Gonorrhœa in the male naturally occupies the most space in this treatise. The author calls particular attention to the importance of making an exact determination of the extent of the inflammation in urethritis blennorrhagica acuta. It is essential to the successful treatment of a given case to know whether the posterior urethra is involved or not. To determine this, the author strongly recommends the following procedure: Let the patient upon arising in the morning, collect his urine into two receptacles. If the urine first passed is cloudy while the last passed is clear, the inflammation is limited to the anterior urethra; if both portions are cloudy, the posterior urethra is involved.

In the hygienic treatment of acute urethritis, he permits the patient to drink a certain quantity of red wine with meals, if the patient has long been accustomed to the use of alcohol. He reviews the usual internal remedies without suggesting any new ones, but describes an instrument devised by himself, which facilitates the injection of liquids into the urethra, and also regulates the pressure employed.

He insists particularly that before the acme of the inflammation is reached, no caustic or astringent injection should be given. The same advice holds good when a posterior urethritis is still in its acutest stage, although the inflammation of the anterior portion of the canal has passed the acme. For the examination of the urethra in chronic cases he recommends Leiter's Electroendoscope, and for sub-mucous inflammation, pressure by means of large sounds and the application of this salve:

℞ Potass iodid.....	5 gr.
Iodidi puri.....	1 gr.
Lanoline .....	95 gr.
Ol. Olivæ.....	6 gr.

This treatise of Docent Finger handles the subject practically and exhaustively. The remarkably extensive bibliographical index appended includes the principal writings on the subject since the year 1494.

W. W. S.

## Selections.

### BLENORRHAGIA OF THE NOSE.

DR. FIRWE, of Christiania, says (*Centralblatt für Chirurgie*,) that in view of the rarity of blenorragia of the nose, due to the infection of gonorrhoeal secretion, we must remember that we have in long standing discharge of pus from the nose, three etiological possibilities.

1. Foreign bodies, disease of the bones and mucous polypi.
2. Secretion of pus from the antrum of Highmore.
3. Secretion of pus from the sinus frontalis.

Whether the pus comes from the antrum highmori or from the frontal sinus, the chances are in favor of the first, because it has been found by experience that empyema of the antrum is much more common than that of the sinus, and the latter apparently always gives local manifestations, while empyema of the antrum can cause discharge of pus from the nose as the only symptom.

### CONTAGIOUSNESS OF LEPROSY.

In a brochure on this subject, reprinted from the *Cronica Médico-Quirirgica de la Habana*, Dr. Enrique Roblin argues on the affirmative side, and cites several cases in support of his position. A negro, Lorenzo by name, 60 years old, of the Ganzá nation, presented all the symptoms of anæsthetic leprosy, and was sent away from the sugar mill in which he was working, to a plantation grove at a distance of about three-quarters of a mile, where he lived in a hut entirely by himself, taking care of the plantain grove and raising chickens. He was visited frequently by his godson, Anastasio, of the Lucumi nation, who carried food to him and often spent some time with him in the hut. After a time Anastasio was attacked with leprosy of the same form, and his wife, a negress born in the country, in whose parents also natives of Cuba, there was no taint of the disease, became similarly effected. Although it is conceivable that the parents of Anastasio may have been leprosy, yet the fact that the leprosy made its appearance only after exposure, speaks very strongly, the author believes, in favor of its having been acquired by contagion; but in the case of his wife there could be no question of hereditary, as her family history was known. These were the only persons on the estate who were attacked by the disease, as they were strictly isolated.

Another case was that of Mrs. Chucha G., 70 years old, a native of Cabañas, Cuba, whose family history was excellent. She had always enjoyed excellent health, and her husband, a strong, robust man, had died a few years before of a fever. All the children, of whom there were several, were living in perfect health, excepting one who had died of an acute disease. Among her nearest relatives was a family living not far away, one member of which, a young man 25 years old, was suffering from leprosy in the ulcerative stage, the ulcers covering the greater part of his body. He was the only member of the family so affected. Doña Chucha visited this family frequently, and was in the habit of washing the bandages and cloths which this young man used to dress his ulcers. After several years the lady noticed that her body was covered with red and elevated patches, and on consul-

tation with several physicians was told that she was suffering from leprosy. The disease progressed from that time until now it is well marked, presenting ulcers, tubercles and anæsthetic sores.

Doña Juana, a widow, with two daughters and one son, had had leprosy for twenty years. Her son was also leprous but her daughters were apparently healthy. One of the latter married Angel Mendez, a Canary Islander, in whose family there was no suspicion of leprosy. They all lived in the same house, and the husband took care of his wife's mother and brother. Some time after coming to live with them, Angel was attacked with leprosy and came under the care of the author. His wife died in childbirth, without ever having presented any symptoms of the disease. Dr. Robelin regards these cases as sufficiently proving the contagiousness of leprosy, any suspicion of heredity being out of the question.

### EXTRA-GENITAL CHANCER.

MOREL Lavallée gives in the *Annales de Dermatologie et de Syphiligraphie*, June 25, 1888, an account of forty-five cases of extra-genital chancre, observed in the service of Professor Fournier, Hôpital St. Louis, during twelve months (February, 1887, to February, 1888), and forty-nine cases by Nivet in the same service during the preceding year. Those of Nivet he added to Fournier's list, making a total of 581 cases, and analyzed them as follows and compared with his own :

Nivet's.		Morel Lavallée's.
Cephalic Chancre.....	71.00	62.50
Chancre of Trunk.....	18.20	25.00
Chancre of Extremities.....	9.30	8.33
Chancre of Neck.....	1.20	4.17

Of chancres of the trunk those of the nipple occur most frequently (8 in 13). Chancre of the tonsil was observed by Morel Lavallée once in forty-eight cases; but according to Nivet nearly five per cent. (29 in 581) of all extra-genital chancres are to be found on the tonsil. This disparity may be accounted for by the difficulty of their recognition in this location. They may simulate tonsillar syphilides, certain tonsillar diphtheroids and a variety of acute tonsillitis not yet described, which is accompanied by induration, ulceration and adenopathy, but which disappear within a few days. In six cases the chin was the seat of the sore. All were men.

Four of Morel Lavallée's forty-five cases had two sores at the same time on regions of the body more or less distant :

1. Chancre of nipple and chancre of eye.
2. Chancre of neck and chancre of eye.
3. Chancre of cheek and chancre of finger.
4. Chancre of upper lip and chancre of prepuce.

The history of the greater number of the above cited cases prove, beyond doubt, that the contamination was of extra-venereal origin.

Syphilis is so frequently contracted outside of the venereal act that it should no longer be looked upon as the wages of sin, and the unfortunate individual as an object of contempt.

The growing frequency of extra-genital chancre, as our knowledge of it increases, and the steady spread of syphilis justifies the demand of the Committee of the Academy for an obligatory course in syphilography for every medical student.

JOURNAL  
OF  
CUTANEOUS  
AND  
GENITO-URINARY DISEASES.

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VOL. VI.

DECEMBER, 1888.

No. 12.

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**Original Communications.**

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**PYÆMIA AS A DIRECT SEQUEL OF GONORRHOEA.<sup>1</sup>**

BY

ROSWELL PARK, A.M., M.D.

Professor of Surgery, Medical Department, University of Buffalo.

ON the 26th of September, 1882, a young German man, set 19 was admitted to the hospital in my care. He had the following history: About a month previously he had contracted a gonorrhœa of ordinary severity, and after continuing for two weeks the discharge had nearly ceased. A few days after that his knee joints began to swell, and he was treated for some days for gonorrhœal rheumatism, by a physician outside of the hospital, but his symptoms becoming worse and his general condition somewhat alarming, he was sent to the hospital.

On admission his left knee joint was found very much swollen, fluctuating, the swelling extending up the thigh, but the joint not being very painful. In the right knee considerable pain was complained of and there was some distension, but no such amount of swelling as in the other. His general condition was what is generally spoken of as typhoidal, his evening temperature high without marked remissions. From the above date his typhoid symptoms increased in severity; his left knee enlarged still further, and when tapped with an aspi-

<sup>1</sup> Read at the Second Annual Meeting of the American Association of Genito-Urinary Surgeons, Washington, September 18, 1888.

rating needle gave a quantity of cloudy serum, in which, under the microscope, a few pus cells were observed. The decubitus became more and more marked, he was delirious at night, his temperature ranged higher, his tongue became dry and brown, sordes collected on the teeth and lips, and he steadily sank with more and more marked symptoms of sepsis. The 2d of October it was observed that he had paresis of the right arm and superficial ulcers of both corneæ; his sphincters were relaxed, and subsultus was noted. He was delirious, and from this condition he gradually sank and died on the 4th of October.

As his septic symptoms became more and more prominent, he made less and less complaint of his painful knees, even their tenderness and sensitiveness on handling largely disappearing. The discharge from which he originally suffered did not reappear, and on admission to the hospital, his general condition being so serious, but little attention was paid to his local trouble. His treatment consisted of the best stimulant and tonic measures which could be instituted, and the only one of his joints which seemed to call for special attention was his left knee, which, as above remarked, was aspirated for the relief of the distension.

A post-mortem examination was made eight hours after death. There were slight evidences of leptomeningitis, and there was acute hydrocephalus internus. There were no thrombi in the sinuses of the brain; the musculature was pale, and there was but little subcutaneous fat. On opening the chest there was found that which was not discovered during life, a collection of pus in the left sterno-clavicular articulation, with carious erosion of the articular surface of the sternum. This abscess contained half an ounce of pus and detritus, and had burrowed posteriorly into the tissues behind the joint; in several of the other joints pus was also discovered, and both knees were filled with pus and débris which had burrowed up posteriorly, destroying the synovial membrane, and, working in among the hamstring muscles, had denuded the posterior surfaces of the lower ends of both femurs of their periosteum. The cartilages, however, were but slightly affected, and the joints presented but very little apparent enlargement. The heart substance was very pale, soft and ænemic; there were adhesions between the right lung and the chest wall; the lungs were œdematous but in other respects normal; the spleen was enlarged and much degenerated; the stomach contained grumous fluid and showed numerous fine disseminated hemorrhages under the mucous membrane. The mesenteric glands were enlarged; the small intestine was studded with very fine tuberculous nodules, almost miliary in size, and displayed the same minute hemorrhages as did the stomach; the bladder was normal; the urethra was a little thickened, but showed no other microscopic traces of recent inflammation. I regret now that a more careful

examination of the prostatic and pelvic veins was not made. The iliac veins contained very thick, dark blood, but no thrombi, so far as examined.

Such was the case, in brief, of a very commonplace attack of gonorrhœa with speedy subsidence of the discharge and pretty rapid death after the first onset of the septic symptoms.

I have gone sufficiently into detail in reporting the *post-mortem* findings, in order that it may be made clear that this was essentially and accurately speaking a case of pyæmia. I do this for more than one reason. There is unfortunately, a carelessness of expression among practitioners by which a septicæmia is called sometimes a pyæmia and *vice versa*. To pathologists the rôle of the veins and of septic thrombi in the production of a genuine pyæmia is well known, and is of importance in the discussion of this case. It is necessary to lay stress upon the part played by bacteria in this production and upon the distribution of minute fragments of these thrombi in the causation of pyæmia, if we are to discuss such cases intelligently. I will not undertake to decide in this case whether the original urethritis was specific, in the sense of having been caused by the specific micro-organism described by Neisser, or whether like many other cases of non-specific venereal catarrhs it lacked this essential element. It is not yet proved that the gonococcus can produce abscess formation, whatever may be said with regard to its acute infectious properties on the surface of mucous membranes. I have more than once repeated the observations of Petrone who withdrew fluid from joints distended as in the ordinary gonorrhœal arthritis, and, under the microscope, have detected in the fluid thus withdrawn the aforesaid gonococcus; but, in no instance, when I have done this, have I found any distinctive pus cells; nor so far as I know has any other observer. The gonococcus itself is cultivated with great difficulty and I have never been able to get a pure culture of it, or one with which I could work with any satisfaction; but I have time and again made cultures from the pus discharged in cases of gonorrhœa of all degrees of severity, from the freshest to the oldest without reference to the gonococcus, and have invariably succeeded in finding one or more forms of the common pyogenic bacteria such as *staphylococcus albus* and *aureus*.

The part played by these organisms in the production of septicæmia and pyæmia is now pretty well understood, and such cases of septic infection can be easily explained as follows:

We have only to suppose that which we know does in many cases occur, that is, a phlebitis either in the neighborhood of the urethra or the prostatic plexus. Once this phlebitis has been aroused the circumstances in no wise differ from those attending any case of pyæmia, except so far as concerns the mere accident of location. Minute thrombi form as a result of the inflammation of the vein, and these thrombi speedily becoming infected, are carried to the right side of the heart, perhaps even without causing thrombosis of the larger veins, and from the heart are distributed all over the body, manifesting as is well known, a peculiar preference for the synovial membranes. Why, in the case which I have reported, there were not found evidences of their action in the lungs, is more than I can state; possibly the fact that the post-mortem was hastily made may account for the absence of these signs. The case occurred before I, or any one else in this country, was undertaking systematic bacterial investigations; nevertheless, I have no doubt that the explanation here offered will stand criticism and experimental proof.

Bumm has treated of mixed gonorrhœal infection, which has been especially elucidated through his researches, and while his studies treat especially of this disease in women, so far as the micro-organisms are concerned, they pertain equally to cases occurring in the other sex. The most frequent agents of this mixed infection are the pyogenic cocci to which I have already alluded. He has, for instance, found evidences of this mixed action in the glands of Bartholini, in the female urethra, in the bladder, in the cervix, and without stating so positively, he feels inclined to claim that we have a mixed infection even in the cases of gonorrhœal arthritis. Before this study of Bumm's appeared, Hoffa had already, as he claims, found in the fluid of a suppurative gonitis of gonorrhœal origin the pyogenic bacteria, but the very fact that the inflammation took on a suppurative form rather than that of simple serous collection would imply that the disease in this instance was of a genuine pyæmic character and not entitled to the name of simple gonorrhœal arthritis. (*Ueber gonorrhœische Mischinfectionem beim weibe. Deutsche Med. Wochschrft.* 1887, No. 49, p. 1057.)

Bockhart also reports two cases of gonorrhœal mixed infection; the first being one of suppurative bubo following urethritis, the second periurethral abscesses. In both cases the staphylococcus was found in the pus from the abscesses.



Gonococci were not found in either case in the pus. This investigator concludes that the great rarity of true pyæmic cases is due to the properties of the white blood corpuscles by which the wandering of organisms away from the urethra is usually combated and defeated. (*Ueber secundärer Infection bei Harnrohrentripper. Monatshft. f. prak. Dermatol.*, 1887. No. 19.)

Andry doubts the occurrence of gonococci in the fluid found in the joints in cases of so-called gonorrhœal rheumatism; it seems to him that the joint symptoms probably occur as reflex phenomena just like, according to his view, the cases of synovitis which follow very slight disturbances of the urethral mucous membrane after passage of the catheter. We have, however, alluded to the almost constant presence of pyogenic bacteria in even the healthy urethra and find it difficult to accept his views, although he allows that suppurative joint inflammations following cases of gonorrhœa are truly secondary infections with pyogenic bacteria. (*Du gonococcus de Neisser, etc. Annales de Dermatol. et de Syphiligraph.* 1887, No. 7.)

Hartley has reported five cases of his own of gonorrhœal arthritis, from each of which he was able also to identify gonococci. (*New York Medical Journal*, 1877, No. 14. p. 376.)

Lustgarten and Mannaberg have made an important contribution to this subject in their studies of the micro-organisms of the normal urethra. They have found in the normal urethral secretion not less than ten different forms of bacteria, four of which were bacilli and six were cocci. One of the former bore close resemblance to the tubercle bacillus. They too have found, as I did, the staphylococcus aureus; also a streptococcus which they call the streptococcus giganteus urethræ. While their studies are simply suggestive so far as our present query is concerned, they are nevertheless of considerable importance. (*Ueber die Mikroorganismen der normalen männlichen Urethra, etc. Vierteljahresschrft. f. Dermatol. U. Syphilis.* 1887 XIV, p. 905.)

Cases like that I have above reported are certainly rare, and one may search through the literature of surgery quite carefully without finding more than a few similar to it. Pyæmia as an immediate and direct sequel of gonorrhœa is mentioned in some of the works as one of extreme rarity and is in many of them confused with septicæmia, or with cases of septic peritonitis, or with cases of endocarditis; in each of which I am not prepared to deny but that the explanation may be essentially the same as I have given above; and yet, at present, I concern myself

especially with the first named and shall have but little to say with regard to the others.

Many observers have noticed cases of peritonitis following gonorrhoea; as to these, almost all of them have occurred in the female sex and are easily explained by migration of the specific processes along the tubes to the peritoneum. The cases of endocarditis or of pericarditis are harder to explain; whether they may be ascribed to the specific gonococcus, or whether they come about after a manner similar to that which I have suggested in the above case, cannot at present be decided. Practically, it is found that septic symptoms are very rare when the primary trouble is confined to the anterior urethra; the further it extends back the greater the possible danger. Septicæmia and pyæmia following operations for relief of stricture are by no means uncommon; such I think may readily be explained by the presence of the pyogenic bacteria invariably found in the discharges, so far at least, as my own examinations may prove. I know of one case in which a patient died of pyæmia after the introduction of a sound for the gradual dilatation of a stricture. It is easy to see how some rent of the mucous membrane may have been caused in this instance and how an entrance for the germs may have thus been furnished.

So far as I have been able, I have collected the reported cases similar to my own. Pitman reports a case in which death was rapid. A young man, æt 25, was admitted to St. George's Hospital in a typhoidal condition; required the use of the catheter; five days after admission was delirious, and three days later died. Between the bladder and the rectum was a large abscess, which communicated with the floor of the prostatic urethra: the prostate was almost destroyed, but in other parts of the pelvis no lesion was discovered. This was more strictly speaking a case of septicæmia. (*Vid.* paper by Post in *Boston Medical and Surgical Journal*, May 5, 1886.)

Vollemier reports a case.—A man with a urethritis and a very painful chordee, "broke" the chordee in true French fashion, and died of purulent infection. At four and a half centimetres from the meatus was a complete rupture of the canal, and the cavernous bodies were almost completely destroyed by suppuration. (p. 9, case 8.)

Another somewhat similar case occurred in the practice of Villeneuve. The patient was suffering from "intense chordee and continual erection, to relieve which twenty leeches were applied. Two days after a scab formed on the most prominent part of the curve; when it fell off the corpora cavernosa were

exposed for the length of three or four centimetres. Rigors, pains in the joints of the upper extremities, purulent effusion into the left elbow joint, and delirium followed, with arterial hemorrhage from the slough on the penis, which caused the patient's death. Phlebitis of the prostatic plexus, metastatic abscesses in the left lung and liver, and pus in the elbow joint were found after death." (*Gazette Hebdom.*, 1873, p. 210. Quoted in "Milton on Gonorrhœa," p. 215.)

In the *Ann. des Mal. Organs Gen.-urin.* (Vol. 2, No. 9), is a case in which the abscess of the prostate was followed by pyæmia. The man was suffering from a second attack; catheterism was performed, followed by bleeding. He died of suppuration and uræmia apparently. Autopsy showed the prostate to be the seat of an abscess which was the cause of the retention, and aside from other evidences there were metastatic abscesses in the lungs, liver and other organs.

Delafield has reported the case of a patient with a specific vaginitis who developed signs of acute cystitis and later marked septic symptoms. At the autopsy, there were found numerous small abscesses in both kidneys, besides ordinary signs of the extension of the disease. (*Vide Post's paper.*)

Blankmeister's case.—A young man, æt 19, the picture of health, contracted an intense gonorrhœa with very severe local symptoms. He was gradually recovering when he caught cold about three weeks after the disease began; this was followed by swelling of the right arm, pain in the back and a general eruption. The arm became more and more sore; fever of an asthenic type set in which gradually became typhoidal; had severe night sweats; the eruption became universal, even appearing on the face. The eruption developed into pustules with which his body became covered; his limbs began to swell, and four or five weeks later he died, having suffered much from ulceration of the skin and underlying structures. (*Jour. d. prakt. Heilk.*, 1839, p. 112.)

In Guy's "Hospital Reports," third series, vol. 5, Habershon reports the case of a young man out of health for several weeks before admission to the hospital. His previous health had been good; he gave a history of gonorrhœal discharge of unknown duration; three days before admission he had a chill followed by fever and pain in right side; he then developed pneumonia at the base of the right lung; he had slight pain in the knees and ankles, but not sufficient to prevent gentle motion; four days later he seemed convalescent, his cough and pain were gone and so were most of the physical signs of his pneumonia. That evening he got up into a sitting posture, complained of faintness, called his nurse, was replaced in bed and in half an hour was dead. At the autopsy, there was found phlebitis of

the prostatic plexus, which contained well-marked clots extending through the iliacs, vena cava, right side of heart and pulmonary arteries throughout the lungs. Whether these clots were from degeneration, or whether the case could be considered strictly a septic or pyæmic one, I cannot gather from the report. Habershon makes the statement that Prescott Hewitt had related to him two instances in which he had observed symptoms of pyæmia of ordinary character produced apparently by gonorrhœa.

Dr. Pierson's case.—(Transactions of the New Jersey State Medical Society for 1862, p. 59.) A previously healthy young man, æt 20, whom he found suffering from what appeared to be chills and fever. A month before his first chill occurred he had had gonorrhœa, which had been treated mainly by internal remedies; the discharge had ceased the day before the first chill. Patient complained of general malaise as well as of local pains and had rigors with profuse perspiration, especially during sleep. He gradually developed distinctive septic symptoms and died some three weeks later.

Drs. Dawson and Jepson. (*Cincinnati Medical Reportory* 1869, vol. 2, p. 67.) A man, æt 47, with a common urethritis, followed by considerable local swelling and œdema, which extended gradually upward onto the abdomen, spreading from one groin to the other, and with gradually developing febrile symptoms of a typhoidal type. The local swelling slowly became gangrenous and was followed by sloughing. The general symptoms increased in severity, and he died ten days after admission to the hospital. The sloughing and local destruction having been quite extensive, there is that in the history which would imply the presence of metastatic abscesses, although not distinctively so stated.

Dr. James H. Hutchinson, (*Medical and Surgical Reporter* for 1876), reports the following case: A young woman admitted to the Hospital with symptoms and history indicating typhoid fever; her general trouble began with a severe chill. On admission she was in a typhoidal condition, and gave the physical signs of pleurisy on the left side and bronchitis. A few days later œdema of the eyelids led to examination of the urine, which was found to contain albumen and pus in large quantities. Searching for the origin of the pus, it was found that she was suffering from a profuse vaginal discharge and this was soon learned to be of specific origin. Her case was diagnosed as a mild pyæmia of gonorrhœal origin. Later she developed some abscesses, but finally recovered.

Dr. Ford reports the case of a young man, æt 29, unmarried, who had a gonorrhœa followed by gleet of six months' duration while at college, ten years previously. Since then he had had

a prostatorrhœa ; he seems to have been subsequently affected with cystitis for a number of years and gradually stricture of the urethra supervened, from which he suffered very severely, both locally and from reflex disturbances ; he seems also to have been afflicted with a chronic pyæmia of which it is difficult to say, whether it followed a gleet or an operation for relief of the stricture, but the earlier symptoms of blood poisoning seem to have set in before the operation ; he had a multitude of metastatic abscesses, which required frequent opening, the last of which was operated upon nearly six months after the first came under observation. He finally recovered, at least so far as to disappear from sight. Still later, it was heard that he had recovered health and strength and was to be married. (*St. Louis Medical and Surgical Journal*, 1881, p. 343.)

Milton in his work on the "Pathology and Treatment of Gonorrhœa," devotes only a page to the consideration of pyæmia as a sequel of it. He simply rehearses, page 253, two cases reported by Charteris, in the *British Medical Journal*, 1876, vol. 2, p. 711. The first case is that of a man suffering from his third attack, admitted to the hospital with chills, high temperature, abscesses in several joints and speedy death. On autopsy, the periosteum was found to be separated along nearly the whole length of the left clavicle with purulent infiltration of the cellular tissue of the neck. The second case was that of a man, æt 30, with gleet, who, worn out by the persistence of his disease took to drink, until he felt the evil effects of this so much that he resumed total abstinence ; his health seems to have quite given way, for Charteris found him with superficial and deep abscesses, several of which were evacuated ; fever, emaciation and night sweats set in, abscesses developed in the liver, he became greatly emaciated and gradually sank. While this case is reported as one of gonorrhœal pyæmia, it lacks the distinctive features, in part, which should ally it to those of which I am particularly speaking.

When we look through the treatises on general surgery, we find but few references to anything of this kind ; for instance, Pepper in the first volume of "Treves's Manual of Surgery," p. 286, says : "I have known it end fatally," and dismisses the subject with these words. Erichsen says of gonorrhœal pyæmia, "It is not easy to draw a clear distinction between gonorrhœal rheumatism and pyæmia. The term pyæmia is applied to those aggravated cases, fortunately of very rare occurrence, in which the joint affection terminates in suppuration with complete destruction of articulation. In these cases abscesses are not uncommonly met with in the body, especially in the subcutaneous tissue. Visceral abscesses are of very rare occurrence. The symptoms are those of chronic pyæmia." (p. 1041.)

Dr. Agnew, in his "Principles and Practice of Surgery" (vol.

2, p. 468), reports the following case: A man of perfect physique contracted a gonorrhœa, which appeared within forty-eight hours after exposure, and developed the most violent symptoms. The virulence of the disease soon created alarm, and Agnew saw him the fifth day of the attack. The local symptoms were intense, severe chills had been experienced; the patient was delirious, with all the signs of pyæmic poisoning. He died within two or three days. While there is no question of the fatality in this case, the only criticism which can be offered on it is that it was rather rapid for the development of classical signs of pyæmia, since these are supposed to require more than eight days—at least such is usually the case.

“One of our fellows, Dr. J. W. White, writing on gonorrhœa in the “International Encyclopedia of Surgery” (vol. 2, p. 344), says: “Pyæmia as a sequence of gonorrhœa, and pelvic cellulitis following the extravasation of urine resulting from the rupture of a gonorrhœal periurethral abscess, are possible accidents, and in spite of their extreme rarity should be borne in mind in the management of these cases.”

Hill and Cooper, in their work, quote three fatal cases of pyæmia, in all of which there was phlebitis of the prostatic plexus, and in all of which, also, the urethral mucous membrane was intact.

While not connected strictly with our subject it may yet be of interest to give the conclusions of one or two French writers on affections of the heart of specific nature following gonorrhœa. Morel, writing in 1883, speaking of the mechanism or means by which such accidents can be produced, alludes to the theory of reflex action advanced by Fournier, to the purely metastatic theory proposed by Swediaur, to Rollet's theory of sympathy, and to the alleged identity of gonorrhœal rheumatism and that of the ordinary type, which was the opinion of Besnier and of Peter. For his own part, however, he concludes that these accidents are different manifestations of a latent septicæmia, as according to the views of Talamon, Lasegue and others, may be an arthritis. Analyzing his observations, one may conclude first, that gonorrhœa may be complicated by inflammation of the serous membranes both of the joints and of the heart; second, that the affections of the heart thus occurring are to be considered as septicæmic accidents; third, that these complications may very rapidly lead to a fatal termination, but that more often they determine a chronic lesion. (Rev. de Therapeut. Medico-Chir., 1883. *La Blennorrhagie et les Affections du Cœur.*)

In a thesis by Dr. Marty, on the subject of gonorrhœal endocarditis, he has not been entirely able to separate the septic elements from the consideration of endo and pericarditis. His conclusions briefly are as follows; gonorrhœa may be complicated by inflammation of any of the serous membranes, and the action upon each of them may be direct; second, rheumatism is not necessarily the connecting link between the specific urethral lesion and that of the separate membrane, although the complication of one with the other may be more or less frequent; third, the organism attacked responds according to its predisposition; fourth, cardiac complications are extremely rare. The orifice most commonly invaded is the aortic. This variety of specific endocarditis seems to present the same symptoms, and the same dangers as simple endocarditis. The endocardium seems to be affected nearly as often as the pericardium, if not as often. (*De l'Endocardite Blennorrhagique. These. de Paris.*)

### Society Transactions.

#### THE AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

SECOND Annual meeting held at Washington, September 17, 18 and 19, 1888.

The President, Dr. Keyes, made a brief address of welcome, in which he spoke of the admirable work done by this Association since its organization and congratulated the members upon the amount and creditable character of the material to be presented at the present session.

The first paper was by DR. ROSWELL E. PARK upon

#### PYÆMIA AS A DIRECT SEQUEL OF GONORRHŒA.<sup>1</sup>

THE PRESIDENT.—This is a suggestive and valuable paper. All are familiar with death following operations of trivial character upon the urethra. But death from pyæmia as a direct sequel of gonorrhœa must be very rare. I have never seen a similar case.

DR. BRYSON.—It is rather an important matter, in connection with the idea which the author has set forth that the case was one of pyæmia the direct sequel of gonorrhœa, to know whether this was the patient's first attack of gonorrhœa. If it was the first attack I agree with the author entirely regarding the rarity and importance of the case. But in the absence of a definite history in the past, the case might have been one of old inflammation lit up anew.

THE PRESIDENT.—That is entirely possible. A deep urethral trouble may be lighted up by sexual contact which is entirely pure; a urethral discharge may follow such contact and result after a few days in serious symptoms. I have seen true pyæmia, pus in the shoulders and various points, come on in a chronic urethral trouble (newly excited to activity). An old affection of the urethra might be excited to a sharp discharge by intercourse, and in various

<sup>1</sup> Page 441.

ways aside from acute gonorrhœa. However, I think the paper valuable as setting forth one of the possibilities in a case of acute gonorrhœa.

The next paper was by DR. BRYSON and DR. BURNETT upon  
CLINICAL OBSERVATIONS ON GONORRHOEA, WITH SPECIAL REFERENCE TO  
ETIOLOGY, DURATION AND TREATMENT.<sup>1</sup>

DR. GEORGE CHISMORE.—I wish to make a few remarks on one method of determining the final cure of gonorrhœa. The reader of the paper mentions the passage of sounds after the morning drop has ceased. I recall the case of a medical gentleman who had not had gonorrhœa for fifteen years. There had in the interval been no discharge; no symptom of any urethral difficulty. A clean bulbous sound was passed five inches into the urethra and withdrawn. Eight hours afterward there was a slight creamy discharge, which under the microscope was found to swarm with gonococci. Twelve hours afterward the discharge had ceased without any treatment whatever.

If the passage of a clean sound fifteen years after the presence of any discharge whatever from the urethra will produce the gonococcus, I do not see how we can base any conclusion as to the final cure of a gonorrhœa upon exemption from a discharge found by the use of a sound.

DR. EDWARD R. PALMER.—It would be interesting to know how Dr. Chismore proved this to be the gonococcus. It seems to me there must be a clinical history pointing with reasonable certainty to gonorrhœa, to enable us to feel very positive that the micro-organism found is the gonococcus of specific gonorrhœa. I believe Professor Webster says that every gonococcus found in the urethra is a microbe of gonorrhœa. It seems to me that according to the limited knowledge which we now possess of the micro-organisms found in the urethra, that it is quite probable those in Dr. Chismore's case were non-specific.

DR. R. W. TAYLOR.—There is but one case on record in which it is known that a gonococcus had given rise to a gonorrhœa. That was in the experiment of Dr. Bumm, who took the twentieth or twenty-second culture of a blenorrhagic ophthalmia, and of the micro-organisms obtained from those cultures, photographs of which are given, he placed some in the urethra of a woman and he says it excited a gonorrhœa. There is an absolute dearth of clinical evidence that men who have the gonococcus in a urethral discharge got the parasite from a woman with whom they had had connection. Until that is proven, we cannot say that it is derived from another person in the way that syphilis is derived from another person. Lustgarten and Mannaberg have shown the presence of the gonococcus of Neisser, or rather of Bumm, in the urethra after chemical or mechanical irritation. It has not been shown whether the presence of the micro-organisms in gonorrhœa is secondary or primary.

DR. F. R. STURGIS.—I am a skeptic regarding the specific nature of a urethral discharge. That the gonococcus is found in many discharges, I freely admit; in many, however, it is also absent, and in the latter cases the course of the disease may be precisely the same clinically as in the so-called specific cases. We find in the smegma removed from beneath the prepuce, in persons who never had any venereal trouble whatever, a micro-organism which resembles very closely the gonococcus of Neisser, or of Bumm, whichever you choose. As to the question of their burrowing beneath the epithelium and into the tissues, it seems to me that if this is true, and the gonococcus is the real cause of gonorrhœa, the disease must be practically incurable unless we strip off all the epithelium and get down to the fibrous layer, and until that is done a clap can never be said to be cured. I do not think Dr. Bumm's case, referred to by Dr. Taylor, was by any means proven.

<sup>1</sup> Will be published in a subsequent number of this Journal.



**THE PRESIDENT.**—I think the question of the gonococcus can be epitomized by saying

The negative value of it is positive.

The positive value of it is entirely negative.

Nothing can give one greater satisfaction than to find on examining a discharge coming on some days after a first sexual contact that it contains no gonococci. Such a patient is entirely free from the poisonous element, and can not give the disease to another. I have acted on this belief a number of times when advising patients, and have not been disappointed, that is the negative thing which is positive. The positive thing, however, is entirely negative. I can not say to a man who has a discharge which is full of gonococci that his discharge is contagious. I say to these persons who may be living with their wives or mistresses that the discharge is full of gonococci, but that the test is not satisfactory. Why in the one case the test is a true guide and falls short in the other, I can not say. I have often taken a shred from the urethra of a patient, demonstrated the gonococcus of Neisser, yet know that the man had been living in close relation with a perfectly clean person and did not communicate the disease. Why he does not communicate the disease, I do not know. I had some patients in Charity Hospital who had pannus, and it was desirable to set up an acute conjunctivitis. I passed sounds upon a patient with a dry urethra but whose urine contained shreds of pus, the remains of an ancient discharge. The purulent flow thus excited was inoculated upon the eyes of the patients with pannus and produced gonorrhœal conjunctivitis. This goes to prove that the poison remains latent in the shreds but assumes new life and extra contagious properties when the urethra in any manner is excited to a new general inflammation.

But I am equally convinced that the gonococcus may exist in a person who is perfectly healthy as far as gonorrhœa is concerned. I have never taught anything else but that there are two forms of gonorrhœa, one a virulent form, one a simple inflammatory form.

**DR TAYLOR.**—My idea is that in the majority of cases there are two factors present in the causation of gonorrhœa; one is a damage to the urethra somewhere, and the other being parasites, lurking about, on the alert to start up irritation at a favorable moment. Accepting those two factors, and arguing therefrom, one can explain about all the questions connected with gonorrhœa.

**THE PRESIDENT.**—Excepting the fact that in different persons the effects vary; in one case the discharge will be virulent, while in another it is not.

**DR. J. P. BRYSON** said, in closing the discussion: We wished simply to bring forward these clinical facts relating to the points discussed in the paper. It seems to me from the remarks which have been made that the questions at issue will most likely have to be settled by clinical observation.

So far as Dr. Chismore's case is concerned, I do not think it disagrees with our observations at all. We have seen quite a number of similar cases, particularly in persons from the country, in whom we do not suspect gonorrhœa at all. In such cases there is no such inflammation as, from a clinical study of the disease, we would suspect to be a gonorrhœa.

**DR. PALMER**, of Louisville, Ky., presented a paper on

#### RETROJECTIONS IN GONORRHOEA,

in which he stated that his experience with the method has been that cases of gonorrhœa in most instances would not get well in less than five or six weeks. An apparent cure would take place within the time claimed by those who advocated retrojections with the bichloride, but a recurrence would take place.

**DR. F. R. STURGIS.**—It is rather unpleasant to be a critic, but on this

old question I wish to say a few words, particularly with regard to treatment of urethritis by deep injections. My results have been more negative than positive. In a few cases, and in one which particularly impressed itself on my mind, the result was extremely happy in the course of three or four days. In the one case the patient returned after some months with a fresh inflammation, and I tried the same method of treatment, but it was a most dismal failure. I have tried the new method in private and Hospital practice, in all about thirty cases were so treated. About twenty followed it up pretty thoroughly three or four weeks, but I am sorry to say that in all the result was the same, and we had to fall back on sulphate of zinc to complete the cure. The instructions regarding the treatment were carefully carried out, the temperature of the water was accurately taken, the retrojections were made carefully and thoroughly by myself and my clinical assistant, and also by the house surgeon of the hospital. Some of the patients would improve three or four days, and then there would be a relapse without any fresh cause for inflammation.

DR. L. BOLTON BANGS.—My experience with retrojections and irrigations has been exceedingly interesting because in my first clumsy efforts in the use of germicides I tortured my patients with too strong a solution of bichloride of mercury, which seemed to be in general the best germicide for use. Then came the hot water retrojection method, but it proved that treatment with hot water at my hands was unsatisfactory to myself and to my patients. In experimenting with this method, I, with the aid of my clinical assistant found it best to reduce the strength of the bi-chloride of mercury to from 1-20,000 to 1-40,000. I do not think the temperature of the water makes the slightest difference. It is not necessary to use a hot injection. I have obtained just as good results by taking water as it runs from the faucet, or having the solution of the temperature of the room in which it stands. I think I can say to my patient who has a true gonorrhœa, there is a possibility of ending it in from two to six weeks; and if we can not end it in so short a time, we can by this treatment render the specific inflammation less painful, and make his condition more comfortable than we could do without it.

DR. R. W. TAYLOR.—I think what Dr. Bangs has said with regard to excessive heat in making the irrigation is well founded. I think if we par-boil our patients it will be unpleasant and unsatisfactory. The nozzle of Kiefer, which has been exhibited, is sometimes very painful, being rough and harsh, and patients flinch under its use. Here is a modification of Dr. Bang's instrument, Dr. Bang's having a shorter nozzle than this. The barrel and the reflux were so good in Dr. Bang's that I did not alter it in those respects, but with this nozzle there is less discomfort to the patient.

THE PRESIDENT.—I believe earnestly in irrigation with a weak solution of the bichloride, nearer 1-40,000 than 1-20,000. I prefer to use it warm. I never use true retrojection until after the acute stage has passed, and seldom then.

DR. J. P. BRYSON.—According to my observation there has been a source of error in reporting cases with this particular treatment. It is not stated how many cases were cured, and where the best results were obtained whether they were cases of fresh gonorrhœa. In our experience we find a great number of cases of old gonorrhœa lit up, especially by surgical procedures. We operate on one man and no inflammatory reaction follows; we operate on another and violent inflammation results, and in the pus we find the gonococcus. I think it is a matter of great importance to state whether the cases are really those of fresh infection. I do not see how we can speak of cases of damaged urethra in connection with this subject. The cases must be cases of gonorrhœa, or they are not. I see non-gonorrhœal cases in which there is extensive damage done the urethra, and it seems in

them difficult to light up any inflammation extending over any considerable time. So far as the use of solutions of bichloride of mercury is concerned, I have always thought when they were used hot that the heat itself acted as an astringent.

**THE PRESIDENT.**—The sharpest urethral discharge which I ever saw produced by the surgeon was a case in which I operated for a urethral fistula. After the operation I irrigated the urethra three or four times a day with a bichloride solution which was altogether too strong. The fistula did well. But about forty-eight hours after the first irrigation the man had a most furious creamy discharge. The irrigations were discontinued, and without other treatment he got well within about three days. No chordee followed the irrigations; nothing but a very profuse purulent discharge.

**DR. PALMER**, in closing the discussion, said: I wish to say a word with reference to the strength of the solution—as strong even as 1-5,000. In some cases it produced great distress, in one it caused such tumefaction of the urethra that it was impossible for the patient to urinate, and I could hardly introduce a catheter. The patient was about eighteen years of age, and had had no previous inflammation of the urethra. I then felt convinced that a solution of 1-10,000 is as strong as should be used; 1-30,000 is better. As to the irrigator or the jack catheter, if the urethra is very sensitive it will not bear the introduction of the catheter; the patient complains even of passing it one or two inches. I think I have seen considerable harm done in passing the soft catheter in inflamed cases. With reference to my cases I should have said the list of 127 also included cases of chronic gonorrhœa. The diagnosis was confirmed by the microscope.

**DR. STURGIS**, of New York, read a paper entitled  
**THE USE OF NITRATE OF SILVER IN THE LOCAL TREATMENT OF CHRONIC URETHRAL DISCHARGES.**

He had been enabled by the use of the endoscope to make direct application of nitrate of silver to the diseased portions of the urethra with satisfactory results. The granular patches become less congested and finally disappeared together with the discharge, after solutions, as strong as sixty grains to the ounce, had been applied.

This with the following paper, "The Diagnosis and Treatment of Chronic Urethritis,"<sup>1</sup> by Dr. Oberländer, of Dresden, Germany, read by Dr. John A. Fordyce, with demonstrations of instruments were discussed together.

**DR. L. BOLTON BANGS.**—I find the use of the endoscope exceedingly unsatisfactory. There is a fallacy in using the short tube in telescoping the urethra. It does make a little hammock and the vision is disturbed. In the use of the endoscope the eye must be trained. I find students cannot see well in the use of reflected light through a narrow tube. I have tried various kinds and have found the dark tube, of whatever material it may be composed, better than clear glass. The light in the latter is diffused. For the use of strong solutions of nitrate of silver in the urethra, I think there is no question regarding the value of the tube.

**DR. TAYLOR.**—In some cases in which it has been difficult to introduce a filiform bougie I have found the endoscope of value, as showing with what we had to deal. A point which has not been sufficiently emphasized relates to the puckering up of the mucous membrane in front of the tube, which has been mistaken for thickening of the membrane and papillomatous growths.

**DR. J. P. BRYSON.**—In using the endoscopic tube I have generally made my observations while withdrawing it, and during the withdrawal make my

<sup>1</sup> Will be published in January number of this Journal.

applications, say of nitrate of silver, perhaps as strong as Dr. Sturgis sometimes employs it, sixty grains to the ounce.

DR. GROSS, of Philadelphia, read a paper upon the CONNECTION BETWEEN MASTURBATION AND STRICTURE OF THE URETHRA, which he had for many years noted, and indeed had found that out of 331 masturbators stricture was present no less than 291 times, usually near the meatus. Gonorrhœa and injury were excluded.

DR. R. F. WEIR.—I am not willing to let this paper pass without putting in a protest against one of the author's conclusions. Dr. Gross has proven very conclusively that in masturbators coarctations of the urethra are met with in vast numbers, but he has not proven that they are due to masturbation. When Dr. Otis first promulgated the idea of stricture of large calibre existing in the urethra, physicians learned to examine the urethra with much more care than they had been in the habit of doing, and from observations which I made in 1879, on persons who had never had venereal disease of the urethra, I learned that strictures, varying in number from one to three, existed in very much the proportion Dr. Gross has given for masturbators. This same narrowing of the urethral canal I found in new-born babes in large numbers. I found it in two instances in which I had opportunity to make the examination in prematurely born infants. And in the absence of anything like inflammatory elements I was forced to the conclusion that we should expect coarctations in the normal urethra. This view has been admitted, I believe, to a certain extent even by those who attributed partly to their influence pathological results following inflammatory troubles. I do not wish to deny that such coarctations of normal character may, under conditions contracted by the patient, aggravate resulting difficulties, but I do think too much stress is laid upon them as being of pathological origin.

DR. R. W. TAYLOR.—I would like to say that I have very firm convictions as to the stenosis about the membranous urethra in masturbators who have not had a previous gleet nor traumatism in the perineum. It consists of a swollen and oedematous mucous membrane with a certain amount of exudation this side of fibrinous change. A condition like that might be called a stenosis, and that it may exist in these masturbators, and be the starting point of reflex troubles which give us so much trouble, I think there can be no doubt.

DR. A. T. CABOT.—I would ask how many of these examinations of the deep urethra in which these strictures were discovered were made under ether. It often happens that the stricture discovered by the bougie-a-boule in that region where the stricture is surrounded by muscular fibres, disappears after the patient is thoroughly under the influence of an anæsthetic, and I think a bougie-a-boule examination in patients of nervous affections, particularly of the urinary organs, is not a safe reliance for a diagnosis of organic stricture.

DR. TAYLOR.—I would say that the use of the bougie-a-boule was only one of the methods of examining these patients. That one could trace the canal from anteriorly backward, and find hyperæmia beginning to show itself about the triangular ligament. I have not put these patients under ether, but have determined the etiological relation rather by way of exclusion.

DR. J. P. BRYSON.—I would say a word with regard to etiology. I agree with Dr. Weir in that it is not proven in these cases that masturbation is the cause of the stricture. The existence of these coarctations, especially in the anterior portion of the urethra, we are not permitted to doubt. A history of two cases of confirmed masturbators was detailed, in which no evidence of stricture was detected. I think, then, that it has not been

proven that masturbation is the cause of the stricture in these cases. I would also suggest the possibility of the stricture being produced in some masturbators by things introduced into the urethra to bring about an emission.

DR. TAYLOR.—In my judgment the trouble begins simply in hyperæmia, the hyperæmia is attested by pain, uneasiness and neurotic troubles from which these people suffer. That hyperæmia does exist, can be shown by the passage of instruments. That it may cause an exudation, which may afterward become more highly organized, there is I think no doubt.

DR. A. W. STEIN.—I believe these coarctations are not pathological in their formation; and that they occur independent of masturbation. The deeper strictures than the mucous membrane are not involved.

THE PRESIDENT.—Regarding the particular subject under discussion I have thought of it since Dr. Gross first called attention to it some years ago, and I have never been able to convince myself that there was any relation between stricture and the habit of masturbating. There is another question which I think underlies this whole subject, particularly that of stricture of the anterior urethra. It is the question of the natural formation of the canal. Some light has been thrown on this question by the æroscystoscope. The inventor of the instrument, Antal, has been unable to find a urethra of uniform calibre. The canal is formed somewhat like the trachea, being composed of rings. When one finds a pathological stricture and divides the fibrous ring so that a smooth instrument will pass without difficulty, he will still find on introducing a bulbous instrument that the canal is ribbed throughout. Some years ago a patient came to me again and again, requesting me to cut his urethra, and I did cut it several times, but later I refused. One day, however, he desired to have a stricture cut, and said he knew he had one and demonstrated its presence by introducing his finger into his urethra and feeling it. Certainly the canal was large enough. The condition which Dr. Taylor has described may also exist in persons who have not masturbated. It is, therefore, a question whether masturbation should be regarded as the cause of it in the cases to which he referred.

MR. REGINALD HARRISON, of Liverpool.—I have not been able myself to trace organic stricture of the urethra to the practice of masturbation. I have, like other surgeons, seen various spasmodic affections of the urethra attended with more or less transient contraction which I believe was due to disturbance of muscular action, but I have not been able to go farther than this.

DR. GROSS, in closing the discussion, said.—In nine-tenths of all masturbators, if an instrument be introduced into the urethra we will find tenderness at certain points, and on arriving at the prostatic urethra the suffering may be excruciating. Not only is there marked irritability and pain on introduction of instruments, but when the man has connection there is great pain. It is also present when he makes water. Following the introduction of an instrument there is loss of more or less blood, from a few drops to a quantity sufficient to annoy the patient as he walks home. I hold, that the masturbator has an inflamed urethra, a urethra which is in a condition of chronic inflammation. It makes no difference how the inflammation arises, it will cause stricture of the passage. And it is on this account that the masturbator suffers so frequently from stricture; it is simply because he has an inflamed urethra.

Let us consider some of the facts of these cases. In 82 per cent. the stricture was situated within the first third of an inch. Let us then leave out of consideration altogether the eighteen cases out of one hundred in which the stricture was situated farther back toward the bladder. Nobody

could mistake these strictures. Taking a bulbous explorer which will barely pass the stricture and one which he can not withdraw without taking hold of the head of the organ and pushing it back over the instrument, and then dividing the cicatricial tissue which is observed to be white and not to bleed, the surgeon becomes convinced of the organic nature of the obstruction. The cicatricial tissue can be demonstrated to the eye in those cases in which the stricture is situated near the meatus and it requires no faith to believe in its existence.

DR. KEYES, of New York, read a paper on

THE CURABILITY OF URETHRAL STRICTURE BY ELECTRICITY.

Observations were made on six selected cases, favorable for testing the method. Two were treated by himself, three by Dr. Fuller, his assistant and one by Dr. Newman in Dr. Fuller's presence. In all cases the result was non-success. Dr. Keyes believes that the claims made for the method are not supported by clinical demonstration.

DR. F. S. WATSON.—As a contribution coming from an entirely independent source, I would like to mention a little experience with electrolysis in urethral stricture of my own. The results were similar to Dr. Keyes's. The number of cases was six, and all the rules laid down by Dr. Newman were observed. In no one of the cases was there a successful result. In the best case a sound two sizes larger than could at first be introduced, was passed at the end of several weeks' treatment. In the first case after electrolysis had been resorted to without success, the stricture was cut.

DR. L. B. BANGS.—I have had some experience with the treatment of stricture by electricity. After having gone a certain distance with it, I got so disgusted that I gave it up. Nevertheless the impression seems to be gaining ground not only in the profession, but also among the laity that we now have a means of positively curing stricture without causing pain. I believe it is altogether a false impression.

DR. F. R. STURGIS.—My experience was one dating back some years ago, when this treatment first came up. I found that it did much more harm than good. But there resulted so much pain and bleeding, and I was so fearful of doing damage, that I gave it up since no good came from it.

DR. TILDEN BROWN, by invitation.—I need hardly say that I have listened with interest to the reading of the paper, particularly as it confirms experiments made by myself. The only thing which occurs to me as confirmatory evidence of what I consider the utter futility of the method is the fact that after I had read my paper, which has been alluded to, Dr. Newman kindly came up and spoke to me, and a gentleman present suggested that Dr. Newman take the second case, which I reported, which had been so pronounced a failure and treat it. He objected on the score of being too busy. We urged him, and assured him the full fees would be paid for the treatment, but despite that fact he declined to accept the case. I told him that if he would take the case and cure it, I would devote all my future to extolling the method, but it was fruitless.

THE PRESIDENT.—I can only say in closing the discussion that it is a great pity to have to raise the question at all, but the method is gaining credence in the mind of the public, and some medical gentlemen have come out in favor of it. I have even seen a notice of some one curing strictures of the rectum by electricity. It is a sort of faith cure. I began the study of the method because patients came to me and wanted to be treated by electricity. I acknowledged ignorance of the method and indifference toward it, but I had no foundation for my non-belief, for no man should accept his belief second-hand; I had not made experiments. But now I have made them with the results recorded in my paper.

DR. OTIS, of New York gave a  
 RESUMÉ OF AN EXPERIENCE OF SEVENTEEN YEARS WITH DILATING  
 URETHROTOMY.

The reader claimed that this treatment possessed advantages over both former and more recently introduced methods. His experience extended over more than a thousand cases and he had never had to record a death or the production of an abscess.

The short, straight instrument alone is recommended. Subsequent observation of cases operated upon did not show that recontraction takes place. The incision must be made carefully in the median line and along the roof of the canal.

DR. W. H. HINGSTON.—While bearing testimony to the great service rendered by Dr. Otis to this department of surgery, there are some things in his paper to which I would take exception. Dr. Otis speaks of an individuality of each urethra. With that I fully agree, but his law as to a relation between the circumference of the flaccid penis and the canal of that urethra, my experience does not indorse. I recollect that once Reginald Harrison entered when I had two patients in the ward, one with a penis of large circumference, the other small, and the one with a large penis had a small urethra, and the one with a small penis had a large urethra. I agree with Dr. Otis. I have very rarely seen sufficient hemorrhage to be alarmed, nor have I seen anything like sexual weakness follow the operation. Regarding division of the meatus, while sexual desire has not been diminished, I must say that I have not seen the force of stream which existed previously. The meatus is the narrowest part of the canal, and it is narrow for a wise purpose: it gives force to the stream.

As regards the true cause of urethral fever, I do not think the passage of urine has much to do with it. In lithæmia I have used an instrument several times without any discomfort whatever to the patient, while I have two cases in mind, in which the introduction of an instrument was followed almost immediately by death, the same instrument being used as in the former cases.

DR. OTIS.—I thank Dr. Hingston for his generous acknowledgment of our efforts in bringing this operation to its present condition. As to the proportionate relation between the circumference of the penis and the size of the urethra, I think I am safe in saying that in careful examinations of two or three thousand cases I have never yet found a single case where the proportion did not hold. I have seen many cases where the size overran two, four and six millimeters, but never one below, and wherever I find a variation, I do not readily accept it, but inquire further and usually find evidence of stricture. I have always found some portion of the urethra which corresponded in size to the circumference, and I have always used the urethrometer in these examinations.

The question of the proper size of the meatus has received very extensive consideration. The fact is that about two cases out of every hundred careful examinations with the urethrotome, show a full size at the meatus equal to the urethra behind it; that there is no contraction, and consequently we will have to say these cases are abnormal or else we will have to say that cases which vary from that size are abnormal. We find this condition of full sized urethral orifice in as great proportion as a perfect relation in other parts. Now, in these cases it will be found, as a rule, that the subjects are free from reflex irritations which are so commonly associated with a contracted orifice. In slight contractions even we sometimes find reflex irritations of a grave character which are at once relieved by bringing the meatus up to the full size. I find in these cases that the subjects are

able to propel their urine to a convenient distance, a distance sufficient for all practical purposes.

Regarding the association of urethral fever with the first passage of urine after operation, I will say I think I did not exaggerate matters at all in claiming that I have seen in a hundred cases with a predisposition to intermittent fever no trouble at all after the regular use, day after day, of the catheter, yet the first time urine was passed over the surface operated upon, sometimes within three or four hours, there would be a sharp urethral chill. In these sensitive cases I make it a point to carry on the use of the catheter if I can, without irritation until the sound is sufficiently healed to prevent this accident.

A paper was presented by DR. E. HENRY FENWICK, of London, on  
THE PROGNOSIS OF ORGANIC STRICTURE OF THE URETHRA.<sup>1</sup>

DR. WATSON, of Boston, presented a paper on  
THE OPERATIVE TREATMENT OF HYPERTROPHY OF THE PROSTATE.

The author suggested that a rationale should underlie operation on the prostate, and a stereopticon demonstration of numerous specimens was made to illustrate his points.

The distensibility of the bladder makes the supra-pubic operation possible, but the operation through the perineum has proved the safer one.

DR. J. P. BRYSON.—I entirely agree with the author of the paper in the opinion expressed with regard to the advisability of the operation under certain circumstances. I think he has very clearly defined the limits of choice of methods, and he has pointed the direction in which we should think and work in the operating room.

My cases of prostatomony for hypertrophic obstructive disease are three in number exclusive of those which I reported last year in connection with removal of stone. The result was disastrous in one case; in another, although it did not destroy life, it failed to relieve the disease which was rapidly doing so, the patient dying, I believe, within two months after the operation. Death was due to pyelo-nephritis, which had already progressed very far before the bladder was opened.

The third case was eminently successful. The patient was near seventy years of age. It seems to me the operation would bring about much better results if it were done earlier, and I believe it will be done earlier and earlier as we gain experience.

DR. GEORGE CHISMORE.—My experience with this operation is limited to one case, that of a man, set 57, who suffered great pain and who passed the catheter many times during the day. I removed a stone by litholapaxy, and at the completion of that operation I made a median perineal incision and found the catheter entered seven and a half inches beyond the perineal incision before urine would flow through it. The distance was so great as to utterly exclude an examination of the viscus with the finger, or even an exploration of the condition at the neck of the bladder. I now think it was probably a case better suited to suprapubic operation.

THE PRESIDENT.—I think Dr. Watson's paper is an admirable one, because hitherto we have been more or less groping. No one had attempted to formulate the conditions indicating the one or the other operation, and I think Dr. Watson has pointed out the course which surgeons will have to adopt.

I can recall two cases of perineal prostatectomy, in both instances removing a fibro-adenoma, in one pedunculated, and in the other not pedunculated. Both patients made a good recovery. In another case I cut a bar at the floor of the prostate. That patient also recovered. One of the patients had

<sup>1</sup> Page 414.



just had pneumonia ; was in a most serious condition. It was out of the question to give ether or chloroform. The suprapubic operation could not be entertained. He was propped up, some cocaine was injected into the perineum, an incision was made and the finger introduced. An enormous prostate was recognized. A drain was introduced. The man quite recovered his general health, went about, and died suddenly after some months of an apoplectic stroke. I have often instituted drainage in cases of enlarged prostate. I have done only two suprapubic operations in cases in which the prostate has been involved in disease. In both the operation was intended to be palliative, as the affection of the prostate was cancerous, and a drainage tube through the perineum could not be borne. One patient died some months after the operation of general cancer, and the other also from rapid progress of the malignant disease which involved the bladder as well as the prostate. The suprapubic operation is certainly going to have a greater future than past. The only point in the paper to which I would take exception refers to exploration. We can very frequently determine the perineal distance without any operation at all by the use of the catheter and the finger introduced into the rectum. We can thus often catch the third lobe and determine whether the median obstacle is a bar or a prominent outgrowth. When it becomes impossible to make a positive diagnosis as to the nature of the obstruction and to determine on what operation should be adopted, instead of doing any operation at once it would be better, I believe, first to explore and establish drainage, let the patient rally, and subsequently operate by the Petersen method.

DR. WATSON said, in closing the discussion.—Every case, in the present stage of this subject, is of value in forwarding our understanding of it. It seems to me we have reached the time when the data are sufficient in quantity and quality to enable us to establish a ground-work on which to build, leaving questions of technique for future development. It is rather surprising, in view of the evidence before us, that Sir Henry Thompson, Guyon and others should set their faces against the procedure. Concerning Dr. Keyes's criticism, I think he is entirely right, that an exploration should first be made by the rectum. One should not be deterred from the operation by the fact that the patient may be apparently at the point of death, at any rate, establish drainage. His condition may change in a short period after drainage, so that a further operative procedure will be without great danger.

DR. POST, of Boston, then read a paper entitled  
PROSTATOTOMY FOR ENLARGED PROSTATE AT THE AGE OF FORTY YEARS.

In this case the prostate was extremely hard, and the patient had suffered for over twenty years, the operation gave full relief.

THE PRESIDENT.—I have seen this hardness of the prostate in only one case, in a middle-aged man. There was extreme hardness, and I did not hesitate to tell the man's friends that I thought he had cancer, although there was no other evidence of it. The tumor had to be cut entirely through, and the patient entirely recovered except for a slight fistula where the drainage tube had been introduced, and which was closed by a subsequent operation. I am unable now to say what was the nature of the tumor, which was certainly as hard as cartilage.

DR. J. P. BRYSON.—I have noticed this extreme hardness of the prostate only in men who had arrived at the age for hypertrophic changes. In one case there was extensive lateral hypertrophy of the lobes and intense hardness, so that had I attempted to press them apart, there probably would have been, as Dr. Post described, an audible giving way.

DR. POST, in closing the discussion, said.—It seems to me quite possible

that in my own case the trouble did not originate from the injury as the patient would have me believe. There was no trace whatever of injury to the perineum. It seems to me quite as probable that the condition had existed at an early age, prior to the injury. There certainly was no question of either cancer or inflammatory disease. There was one peculiarity about the operation, which can not be common in prostatotomy, that is that the knife was obliged to precede the finger, cutting its way blindly.

A paper upon

THE HISTORY OF THE FILARIA SANGUINIS HÆMINIS. ITS DISCOVERY IN THE UNITED STATES, AND ESPECIALLY THE RELATION OF PARASITE TO CHYLOCLE OF THE TUNICA VAGINALIS TESTIS

was read by DR. WM. M. MASTER'S, of Mobile, Ala.

THE PRESIDENT.—I have here a specimen of hæmato-chylous urine, from a man whose blood always contains the filaria. The patient is a resident of Charleston, a white man, thus affected for thirteen years. He has tried a great number of remedies but without effect. He can always produce chylous urine, and if he wishes can produce blood as well as chyle by a jolting exercise. The parasite could be found only at night usually, but if he kept the bed during the day it would be found then, and not at night when he walked about. He has never been out of the United States.

DR. BANGS, of New York, presented some

CLINICAL OBSERVATIONS ON DISEASES OF THE TESTICLES.

The diagnosis is not easy. In most cases there has been injury, or an extension of inflammation from the prostatic urethra. Tubercular testicles often simulate cancer, and simple inflammation may resemble tuberculosis.

DR. F. S. WATSON.—I would ask the views of the members of the Association with regard to the treatment of tuberculous enlargements of the epididymis and testicle in their early stages. I have in mind two cases which were let alone and I had the sorrow to watch them through to a dreadful termination, for in its course the tuberculous disease involved the whole genito-urinary tract from the testicle to the kidneys, and inflicted horrible suffering on the patients. In both cases the disease started in a small nodule, and the question arises as to the value of early excision of such nodules.

THE PRESIDENT.—It is quite likely that tuberculosis of the testicle is like that of the lungs, being of different varieties. There is not any doubt that in many instances it is entirely curable; in other cases it recurs with great rapidity. Probably in most cases the disease appears in the prostate before it gets to the testicle. *Post-mortem* examinations have shown that where the prostate appeared healthy to the finger cicatrices are found in the prostatic sinus. I believe that thorough scraping of the affected part is as effective as excision of the testicle. Patients who have had one testicle removed have come to me within six months with the disease in the other testicle.

DR. J. P. BRYSON.—Concerning one or two points in the paper I will give my own experience. In the first place, as far as operative treatment of tubercular disease of the testicle is concerned, I am gradually letting the testicle alone. I have been somewhat unfortunate in seeing quite a number of cases of tubercular disease of the genito-urinary tract. Tubercular disease of the kidney may exist a long time without causing great disturbance, or giving any evidence of its existence. One of my patients had been in Colorado a long time with the belief that he had diabetes, and it was found at death that he had extensive tubercular disease of the genito-urinary tract. A young man came to me three years ago. In one testicle there were three hard nodules. The disease being disseminated and the nodules not quite

regular. I believed the diagnosis to be tuberculosis. I advised him to have it removed. Soon after he saw me there was evidence of the testicle breaking down. After careful examination I could not feel at any time the slightest nodular condition of the cord; it seemed to be free from disease. There was a good deal of pain in the testicle. I removed that testicle and had a good result, but I took pains during the operation to squeeze the fluid from the proximal end of the vas deferens, and in that fluid were found several tubercle bacilli. If at that early stage of the disease the tubercle bacillus existed along the duct, certainly operations must be performed much earlier than patients will ordinarily consent to have them done before we can hope for good results.

One other point to which I would refer is that the onset of the tubercular inflammation of the testicle or epididymis is often very sudden. In one case the patient accidentally squeezed his testicle slightly, and within two days afterwards it was double its normal size. That patient died of tubercular disease of the genito-urinary tract.

DR. R. W. TAYLOR.—I think tuberculosis of the testis exists under three conditions: First, it usually begins in the epididymis and it may be primary; second, it may exist in the epididymis which has been the seat of a previous inflammation; third, it may be an extension of the process from the prostatic urethra. Under those three conditions I have many times demonstrated the disease.

There are two modes of invasion: it may be chronic or it may be sub-acute or acute. The pain is in proportion to the acuteness of the attack. In evidence of the acuteness of the disease in some cases, I have seen the parts converted into an abscess in less than two weeks.

The presence of the bacillus is very difficult to demonstrate. The morbid process diffuses itself very rapidly and we know it is one of the principles of surgery to-day to extirpate all tubercular foci possible. It is fair to assume from what we know of clinical and pathological evidence that a testicle which is the seat of tubercular infiltration is no longer a secreting, a generating organ. Under these circumstances I think it is rational and conservative surgery to take away the testicle which simply encumbers the scrotum.

DR. ROCKWELL, of Brooklyn, whose paper bore the title

CASE OF REMOVAL OF BOTH TESTICLES FOR RECURRENT CARCINOMA,

read the history of a case in which a hard nodule was first noticed in the epididymis, which increased until the epididymis was six times its normal size. It was removed, and found to be scirrhus cancer. Some months later the opposite epididymis was similarly affected, and removal showed the same disease.

THE PRESIDENT.—A man with a testicle is not a eunuch, whether his duct is occluded or not; he may yet have any amount of vigor. But without a testicle he is rather flabby in a moral way. Statistics, I think, are rather against extirpation, and the evidence in this direction is growing stronger. Very often the disease commences above and is spontaneously cured there, and does not necessarily begin in the testicle as it may seem to do. The patient may live a number of years without as well as with an operation. In the rapid form it frequently recurs and attacks the other testicle, although there had been no previous disease in that testicle. Local extirpation is no guarantee of cure.

DR. TAYLOR.—That there may have been a chronic exudation which, being allowed to remain, broke down, and there was then engrafted a purulent process on the tubercular disease.

DR. WATSON.—In my case, I believe, a full year elapsed during which the nodule remained confined to one epididymis, and it appeared to me that something might have been done before general infiltration took place.

THE PRESIDENT.—It is an important question which has not been fully solved. I think the tendency of modern operators is, when they find a tubercular focus, to cut it out under the impression of ending the trouble. But it is not the end of the trouble. There has often been a tubercular process elsewhere, and I believe the clinical results will give a tendency in the future toward greater conservatism.

DR. BRYSON.—I believe we do encounter cases where we are in duty bound to operate; but the question is, shall the whole testicle or only the diseased portion be removed. I have scraped the diseased portion of the testicle away and had it heal admirably. There is another course which tubercular disease may take. The testicle remains perfectly normal so far as can be determined by an examination. Yet there is plainly disease of the kidney, bladder, and prostate. Thus the disease does not always travel down.

DR. A. W. STEIN, of New York, read a paper upon some points in the DIFFERENTIAL DIAGNOSIS OF BLADDER AND KIDNEY AFFECTIONS.<sup>1</sup>

DR. F. S. WATSON, called attention to the diagnostic value, in addition to the means enumerated by Dr. Stein, of puncture of the kidneys by exploring needles, as practiced by Mr. Morris, of London, in cases of calculus nephritis.

DR. ANNANDALE, of Scotland, emphasized the importance of the use of the cystoscope, and in illustration referred to an obscure case of hæmaturia due, as the autopsy revealed, to pelvic sarcoma. Here the cystoscope would have shown the blood flow is from the corresponding ureter, indicating the location of the disease and the proper procedure in treatment.

THE PRESIDENT thought none of the instruments which Dr. Stein had so cleverly demonstrated could be relied upon very much. He preferred other means, notably, the kidney cell, the sound cell one-third larger than the pus corpuscle, the relative amount of albumin compared with the pus and all the ordinary well-known physical signs.

The most positive criticism of the value of catheterization of the ureter is embodied in the history of a woman who passed as having disease of the bladder while under the care of some of the most eminent physicians of this country. She had her bladder washed out daily for over a year. She suffered for four or five years under the care of physicians in this country and none suspected that she had disease of the kidney. Finally she went to Strasburg and it was there located; the left kidney was found to be enlarged and pouched. An operation was suggested but not insisted on and she concluded to come home and have the operation done. Freund, an eminently competent and careful man, catheterized the right ureter, examined the urine, found nothing abnormal with it, and pronounced the right kidney absolutely sound. The patient came home, grew worse and fell into my hands. She was then bedridden, had a high temperature, had pus in the urine, and was in a deplorable condition. The kidney was larger than the head of an infant, and pouched forward; was prominent below the ribs. There was no doubt about the disease of the one kidney, and Freund's statement regarding the healthy condition of the other had a good deal of weight with me, and induced me to take out the left organ. I removed it anteriorly, and had a very desperate operation. Besides being very large, the kidney was attached to the transverse colon, and contained a number of abscesses which were incised, letting out about a pint of thick pus, before the kidney was re-

<sup>1</sup> Page 370.

moved. The capsule was immensely thickened. The other kidney was felt. It was small, hard, distinctly contracted and I pronounced it unsound. Since no casts had been present in the urine, it was thought possible that it might enlarge and do its work, and the operation for the removal of the left was completed. After the operation the patient did well as to the wound, badly in all other respects. The urine, which had contained pus, cleared up. Things began to look very hopeful until it became evident that the urinary secretion was becoming more and more scanty. I should have said there had always been from one-half to one and a half per cent. of albumin in this perfectly clear urine, and occasionally very thin hyaline casts and very seldom a granular cast. She went on about eight weeks and died practically of suppression of urine. The right kidney had been cirrhotic. Thus all the care taken to determine the condition of the right kidney failed and the patient's life was not saved by the operation.

As to the cystoscope. I regard it as a valuable means of diagnosis when one has educated himself sufficiently in the use of it. But the inexperienced observer cannot do much with it.

DR. CHISMORE.—A gentleman stepped from a car and felt a pain in the lumbar region, which ceased in a moment and he had no further disturbance. Shortly after this I found a tumor and diagnosticated abscess of the liver. Nearly a pint of pus was withdrawn by aspiration. The man's health was failing, and consequently it was decided to open his abdomen, when a multilocular tumor was found which contained fluid, some of it being pus, some being clear. It was only after taking the tumor out that it was proven to be the kidney. The origin of the trouble was a uric acid calculus which completely occluded the ureter and led to pyonephrosis and hydronephrosis. Yet it had been unattended with any symptoms referred to the genito-urinary system, and only by a momentary pain in the lumbar region.

DR. STEIN said, in closing the discussion.—I had not the time to take up all the points which might have been discussed in the paper. What I wanted to show was, that albumin in the urine, the character of the cells, the round ones not excepted, or any form of epithelium whatever, was purely a diagnostic sign of disease of the kidney. Pus is not. We can make out a diseased bladder by the cystoscope, and still have to determine whether there is disease of the kidney. If we do not find disease of the bladder, then the symptoms must be due to disease of one or the other kidney. The question of which kidney is affected may sometimes be determined by collecting the urine as it flows from the one or the other ureter. I did not speak of diagnosis by puncture of the kidney with the needle, after Morrison, nor of certain other methods, as it would have led me too far.

DR. OTIS, of New York, demonstrated a PERFECTED EVACUATOR, and proposed AN IMPROVEMENT IN THE METHOD OF REMOVAL OF DÉBRIS FROM THE BLADDER.

The reader discussed the evacuators of Bigelow and Thompson, but considered that his own which he had presented at the New York Academy of Medicine some two years ago, was about as perfect as he could desire. No regurgitation took place and there was no strainer or valve to encumber the instrument, and it was much lighter than either of the others.

THE PRESIDENT.—I have used about every kind of evacuator excepting Guyon's and Ultzman's, and thus far prefer Bigelow's. But different operators are likely to become accustomed to certain instruments and to prefer them to others. Guyon uses a most curious thing, containing what appears to be an unnecessary angle, yet he gets the best results. His last report embodies several hundred cases with only about two and a half per cent.

mortality, which are the best results in the world. I think only two things remain to make Dr. Otis's instrument absolutely perfect: a change in the position of the hand bulb and a certain means of excluding air. I have used one of his instruments very successfully in removing an ounce stone within nineteen minutes. The evacuator worked very quickly and satisfactorily. But it annoyed me because I am in the habit of relying on the sense of hearing more than that of sight as to the progress of the washing, and in Otis's instrument at that time air could not be kept out of the receiver.

DR. KINGSTON, of Montreal, read a paper upon

OPERATIONS ON THE KIDNEY.

He preferred the post-perineal operation for removal of the kidney, and raised the question of the number of ribs to be divided. This was discussed in connection with the next paper by DR. ROCKWELL, of Brooklyn, on a case of

NEPHRO-LITHIASIS COMPLICATED WITH HYDRONEPHROSIS.

In this case lumbar nephrotomy was performed. The patient has had nephritic calculi as a boy, and recent marked symptoms. The posterior incision was the one made, but no stone was found. Subsequently the patient passed a calculus and relief followed. The reader thought the palpation of the kidney had hastened the passage of the stone.

DR. PARKS.—I will relate the case from which the stone, which I now exhibit, was removed. I saw the gentleman early in last May. Although healthy in general appearance, he gave the history that for ten years he had been having intermittent attacks of very intense pain in the left kidney lasting for two or three days, with severe chills, and followed by a discharge of turbid urine consisting principally of pus. This discharge would continue a day or thirty-six hours, the pus would gradually disappear and he would be well of the attack. I was convinced that his trouble depended upon some foreign substance in the kidney, and therefore advised an operation to which he consented. I made the usual incision, but found that it was impossible to fix the kidney, the incision was enlarged until the finger could reach beneath it. The tissues tore so easily that any attempt to fix the organ proved abortive. I then punctured it with needles in several directions, with no result whatever. I then introduced my finger into the wound, forced it around to the posterior surface of the kidney, and there it came in contact with a hard body. I then attempted to open the kidney from the posterior border by means of the cautery, but it was impossible to fix it in any definite position. Finally I made a clean incision and uncovered the stone; it was not loose in a sac, but was grasped very tightly on all its surfaces, and required a good deal of pressing and teasing to fully uncover it, when it was removed by a pair of slender dressing forceps. The man had only very slight elevation of temperature subsequent to the operation. At the end of two weeks the wound was practically closed, and he recovered without difficulty.

In this connection I may state a little experience which I have had with nephrectomy. I removed the kidney for tubercular degeneration. The organ having enlarged to the size of one's head, extending from the margin of the last rib well down to the pelvis and over the abdomen. I removed it by posterior incision, prolonging it downward and forward as far as the anterior superior spinous process of the ilium and two inches above it, and at the same time striking a mid line between the rib and crest of the ilium, and extended the incision backward in a semilunar direction. The point of the rib could be retracted easily, and there was no difficulty at all in carrying the peritoneum out of the way, and thus leaving an immense wound

through which the kidney could be removed and the vessel secured with ease.

With regard to Professor Hingston's remarks on differential diagnosis, I think circumscribed resonance in the lower part of the abdomen and to one side is not a reliable sign of kidney tumor. I have in mind one instance of ovarian tumor in which every portion of the abdominal cavity was dull on percussion except a small area at the lower right iliac region, but when the operation was performed universal adhesions were found, except at that point of insertion of the pedicle. The diagnosis of ovarian tumor proved correct, and we were saved the error of mistaking the tumor for a kidney.

SIR WILLIAM MCCORMAC.—I only heard the last words of Dr. Rockwell's paper, describing a case in which he searched for a stone in the kidney which was afterward passed. This reminds me of a case of a young man, very muscular, and apparently in the full vigor of life, who had such distinct signs of stone in the kidney that at St. Bartholomew's a lumbar operation was performed but no stone could be found. He came under my care at St. Thomas's, and the symptoms were then very severe. Knowing the negative issue of the former operation I hesitated to repeat any operative interference. I carefully searched the bladder to assure myself there was nothing there. I sent him away from the hospital, after a time he returned, complaining of his intolerable pain. I found at one point corresponding to about the middle of the ureter greater pain than elsewhere, and it seemed an exploratory operation was justifiable. I opened the abdomen and searched the ureter from one end to the other without being able to discover anything. I am able to complete the history of this case by having accidentally learned from a recruiting surgeon that the young man had afterward applied for admission to the army and at that time was perfectly well.

There is another matter I would like much to have your opinion upon. It has so happened that recently, at short intervals, I have had three boys under observation who had been run over in the streets of London. These boys, as a result of the accident, had each one of them a rupture, I presume of the kidney, which was followed by a large hydronephrosis. The tumor in each case occupied the whole flank, extended beyond the median line, and reached down into the iliac fossa. The first case was treated by tapping, and at each successive tapping the fluid withdrawn showed less markedly the elements of urine. After a few tapplings this boy recovered. In the second case the tapplings by the aspirator were continued about a year, and were very numerous, but this method of treatment wholly failed. I made a drainage opening under antiseptic precautions, but that failed to obliterate the sac, and finally I extirpated the remains of the kidney and the boy got well. The third case is still under treatment. I tapped him three times, but the tumor refilled, and I would now like to know what it is best to do for the boy, whether to continue the tapping, or in view of failure in the second case, to at once extirpate the remains of the kidney, or adopt some other measure.

DR. FRED. LANGE.—With reference to whether the lumbar or abdominal incision should be preferred I hold to a certain principle. I have always done the lumbar operation for this reason, that I have only operated for pyo-nephrosis, the number of cases being eight. In these cases we have to deal with an organ which is infected, which cannot be handled aseptically and the wound is very likely to be infected. If the peritoneum be traversed the patient's life will thus be placed in jeopardy. For this sole reason I have always made the lumbar incision. On the other hand, I am quite convinced that this incision gives less space. That the removal is much more difficult, that in some cases it will be attended by greater loss of blood. In the case of tumors where there is no danger of infecting the peritoneal cavity by pus, the abdominal incision would be preferable.

At the last congress of surgeons, at Berlin, I took occasion to mention my experience with stone in the kidney. When we look at the normal kidney we see that its pelvis is not inserted in the median line, but that its insertion is more toward its posterior border, behind the junction of the main vessels. We have not to contend with the peritoneum, and we have the possibility of pushing the yielding parts toward the anterior abdominal walls, while in operating anteriorly the kidney would be pushed toward the posterior, unyielding side. Access to the pelvis of the kidney in some persons I judge to be easy. When the kidney is placed somewhat downward, which is not unusual, and when the patient is not very fat, it is a pretty easy thing to lay the kidney bare, open the pelvis, and explore the ureter. I have done that with comparative ease in several instances. On the other hand, the operation can be extremely difficult, and I think impossible in some cases in which the organ is enlarged, the substance of the kidney overlapping the pelvis. In several cases of stone in the kidney it was by mere guess work and accident that I sounded the stone. We will also have to give especial care to those cases in which the body of the stone is located in the kidney and has many facets radiating into the calices. The disengagement of these ramifying stones is, in the living subject, very tedious, and not without danger in so far that we are apt to break one of the protrusions off, be unable to find it, and leave it as the nucleus for further stone formation. In these cases, also, we have to go through the substance of the kidney since the pelvis is overlapped. The portion of the stone which the operator first reaches may be a projection; from that he must work his way to the body of the stone, and then carefully uncover the several projections. I have devised some instruments to aid in these cases which I have in my hands, they are described in the *Centralblatt für Chirurgie*. I think it is surgical vandalism to remove the kidney so long as there is the faintest possibility of removing the stone alone.

An unsuccessful probatory incision, not finding the stone, has happened to me also. Although I had the moral conviction that the stone must be present, I could not find it after a most thorough examination, palpating the kidney, making numerous punctures. But I could not make up my mind to remove the organ for the reason that there are cases on record in which the symptoms have pointed to stone on one side when it was found to exist on the other. I think it would be better to make a probatory incision on the opposite side also before removing the painful kidney, thus removing the possibility of error. In several of my cases, after some waiting, the stone has been passed.

DR. W. GILL WYLIE.—In doing considerable abdominal surgery in women, it has happened to me to come across a good many cases of dislocated kidney or kidneys which were enlarged. The past four years I have operated upon seven cases, in four of which I removed the kidney. In all the kidney was either dislocated or enlarged. In five the operation was by abdominal section, and in two a posterior incision was resorted to in order to fix the movable kidney.

As to whether the anterior or posterior operation should be resorted to, it was but natural for me, in doing abdominal surgery for pelvic tumors, to take up the anterior operation. And I have little doubt that when the kidney is loose from its natural bed or is enlarged, that the anterior operation is by far the easier and safer.

In all the cases of kidney disease which have been under my care, only two were sent me with a previous diagnosis of the kidney affection by physicians. The remainder were discovered in searching for or in examining patients with abdominal tumors. I had no special difficulty in excluding ovarian or pelvic tumors. That is probably due to the fact that the tumor was not very large excepting in the one instance. There was some doubt



as to the character of the tumor until the abdomen was opened when my diagnosis was confirmed. It was extremely adherent to the colon and mesentery, and was very much like an ovarian tumor in thickness and general appearance. It contained thirty-two ounces of serous fluid. It had no odor of urine. There was some pus in the fluid. I entered the sac after withdrawing the fluid, held it in one hand, and with the finger nails enucleated it from the surrounding tissues, and during this procedure discovered another cyst apparently higher up, and more nearly in the locality of the normal kidney. Without much difficulty I removed the kidney and cut off the pedicle low down, and found in the ureter a broken piece of stone and some pus. Although the patient was seventy-two years of age, there was no shock, and she made a good recovery.

Unless we have every reason to believe that the kidney contains pus and septic matter I should not hesitate to operate anteriorly. If I believe the fluid to be septic, I should prefer the posterior incision and drainage. If I found that I could not readily remove the tumor posteriorly I would close the wound and subsequently open anteriorly. If I employed drainage I should use a glass tube, for the rubber tube is likely to be closed by pressure.

DR. RANDSHOFT.—I have had occasion only once to remove the kidney. In this case I regret very much indeed that the abdominal incision was resorted to. This was done because the diagnosis was decidedly uncertain, and the operation was in the nature of an exploratory one in the beginning, until it was found the tumor was a hydronephrotic one when it was too late to resort to the posterior operation for its removal. Unfortunately the kidney was soft and very readily broke down, furnishing the very best possible means for septic infection which carried the patient off. In most ordinary cases I doubt not that in the future abdominal section will be resorted to, and not the posterior operation, but in septic cases the latter method will be employed.

DR. R. F. WEIR.—I have had two cases of nephrectomy, have operated in three cases for stone in the kidney, one case was very similar to that of Dr. Rockwell. It occurred in a woman who had agonizing renal colic. The kidney was exposed by the usual vertical lumbar incision, it was palpated first on its posterior surface, then on the anterior: The entire hand was then introduced into the wound, and with the finger posteriorly and the thumb anteriorly, the kidney was rubbed all over, but nothing was discovered. The operation was abandoned, but within twenty-four hours the patient was free from pain, the urine was a little more bloody, it contained considerable uric acid crystals, but no stone. The conviction was forced upon me that a recently formed calculus had given rise to the trouble.

In the other two cases the removal of the calculi was secondary to an operation on a pyelitic kidney. I made the lumbar incision, emptied the kidney of its pus, and in one thoroughly washed out the kidney. The regurgitant action of the fluid brought out a stone in one case, but not in the other. In this case I found the stone in the kidney and after considerable trouble and tearing of the organ I extracted it.

One would hardly venture to suggest to Sir William MacCormac a solution of the question he has raised, but when we reflect upon the tolerably good success which attends nephrotomy for hydronephrosis it would seem that his patient should still have the benefit of the procedure. Although in the previous case he found that drainage was ineffectual, yet it would seem his patient should have the benefit of the trial before extirpating the kidney.

In the examination of the kidney after the lumbar incision, the opening should be made sufficiently large to permit of the introduction of the entire hand, not only for exploratory purposes, but also in removal of the offending body. When a suppurating process is present we should resort to the lumbar incision. Still, there are cases in which this procedure may be

departed from. The reason for fearing the anterior incision is the danger of opening the peritoneal cavity, yet we hope to pull out the kidney, even in inflammatory conditions, without opening the peritoneum when we make the posterior incision. On opening the peritoneum anteriorly, why may we not pull up the organ on the abdominal wound, allowing no pus to enter the peritoneal cavity, and thus complete the transperitoneal operation. As regards removal of the kidney for tumor, the tumor should be removed by anterior incision, posterior drainage employed and the posterior cut in the peritoneum closed. The peritoneal cavity is thus entirely cut off from the wound cavity.

MR. ANNANDALE.—I may be allowed to express an opinion as to the best method of performing nephrectomy. It is better for exploratory purposes in the first place, and also for removal of the kidney afterward, to attack it by the lumbar incision. The advantage of this incision is that you are well behind the peritoneum, and if necessary, the incision can be prolonged forward, or one be made at right angles to the first. You can get thus all the advantages of the anterior incision. I have operated in a few cases of movable kidney for the purpose of fixing it, and the principal point consists in getting as good a bed for the organ as possible. If necessary, some of the fatty textures should be removed. In my cases the result has been satisfactory. In one case I not only stitched up the kidney in place, but emptied a cyst and drained.

THE PRESIDENT.—My experience has been limited to two primary nephrotomies and two secondary nephrectomies. In two nephrotomies which I have performed, one was in a stubby man. Only the lower third of the kidney could be reached and a little stone was removed, and the man did well, but the exploration was entirely unsatisfactory to me. The other man was tall, and the kidney could be reached and palpated through the posterior incision with ease. The difference in facility of operating when the posterior space is small and when large is very considerable. It was exceedingly fortunate for Dr. Rockwell's patient that the stone was discharged at all. He has still intermittent pain and he is taking almost exclusively a milk diet which makes him feel a little better, but his condition is none too good. The urine is still relatively as full of pus as before the operation, and it is not impossible that there is a stone in the kidney yet. As to Sir William MacCormac's case, it seems to me the circumstances are not exactly like those of a hydro-nephrotic kidney. There has been an escape of urine outside of the kidney from rupture of the organ, and probably in the cellular tissue about there is a sac containing urine and which it would be difficult to close by drainage without first extirpating the kidney. This is especially probable, since in an analogous case a fistula formed for drainage refused to close.

DR. LANGE.—I would ask those present whether they have found patients with an extirpated kidney apt to get up a psychosis. Among my patients two had for a number of weeks mental disturbance, one having hallucinations of persecution, and being very violent. Both got well. The possibility of iodoform poisoning in these cases was absolutely excluded. As to the after treatment, the only proper method is the open antiseptic treatment.

I do not touch cases of hydronephrosis as long as the patient does not suffer, and the size of the tumor is not so great as to interfere with the enjoyment of life. In some cases of nephrectomy and hydronephrosis we have a comparatively smooth result while in others the patient's condition becomes lamentable.

MR. ANNANDALE.—I have exposed the kidney six or ten times for supposed stone, and although no stone was found yet the patient's symptoms disappeared.

DR. G. R. FOWLER.—I was consulted by a lady of about fifty years, who had symptoms of nephrolithiasis. There was no pus in the urine, but it occasionally contained blood, oxalates and phosphates. Her sufferings were so severe that I finally made an abdominal incision for exploratory purposes, but could detect nothing wrong in the kidneys. Her sufferings continuing and even increasing, and I was finally induced, a year later, to make a lumbar incision over the left kidney. Again nothing was found, but to my great surprise the patient made a complete recovery after the lumbar incision, while no benefit had followed the abdominal incision.

THE PRESIDENT.—I never read of a case in which the probability of the existence of a stone in the kidney was greater than one in which I made an exploratory incision. I had previously removed a stone from the bladder. The kidney was thoroughly palpated, punctured with a needle, and every effort was made to feel the stone, but it failed. The patient got much better after the exploration; the passage of blood ceased, but the urine still contained pus. There was no stone passed and no shower of crystals.

DR. HINGSTON, in closing, said.—Professor Park misunderstood me with regard to the area of resonance in the diagnosis of disease of the kidney. What I meant to say was that resonance to the left of the umbilicus and below the rib, at a greater or less distance, and found only on carefully looking for it, was indicative of an enlargement of the kidney. On three occasions it was that circumstance alone which led me to diagnosticate tumor of the kidney and not a tumor of the ovary or spleen.

I am glad to hear Mr. Annandale prefers lumbar incision, which gives quite as much space as is obtained from in front. In the case of a displaced kidney two or three times its normal size, I removed it with less difficulty than I have had in removing any ovarian cyst. Why should we prefer the posterior method for sounding, and the anterior for operating?

DR. ROCKWELL, in his closing remarks said.—I have very little to add to the discussion which has been so complete. The paper was presented as a text, and it has served admirably the purpose for which it was presented. The rules for operative treatment, I think, are pretty well established.

DR. HARRISON, of Liverpool, England, presented a paper on

#### PERINEAL LITHOTRITY.

The advantages claimed for the procedure being digital exploration, rapid evacuation and drainage, and that its employment would lessen the number of recurrences following litholapaxy.

DR. GEORGE CHISHMORE.—In making a litholapaxy a short time ago in a case with hypertrophy of the lower segment of the bladder, I found after having removed the stone by the ordinary operation of litholapaxy and making a perineal opening for the purpose of establishing drainage, that I could not get my finger into the bladder. The stone appeared to reside entirely in the upper portion of the bladder. It was the published observations of the author that led me to make the perineal incision with the hope of enabling the man to pass his water without the aid of the catheter when he should recover.

DR. J. P. BRYSON.—At the first meeting of this Association I called attention to four cases occurring in my own practice; in two of which I had done the identical operation that has been described here, and for the same reasons. It has been my fortune to find what I took to be enlargement of the prostate due to inflammatory troubles, connected with stone in the bladder. Consequently I have thought the cases came under the class due to causes existing in the bladder.

In one case any irregularity in diet resulted in renal colic with the

passage of a good deal of calculous material. But the bladder was always empty. Finally the man passed the age of 54, and his prostate enlarged. Subsequent to that he had an inflammation of the bladder, and then he had what I considered the conditions necessary for the formation of stone, and I believe the stone formed because of the cystitis. I operated by median perineal incision and found the stone of such shape that I did not have to crush it in that case. The man made a perfect recovery after the bladder had been drained. In the other case, that of a young man, there was considerable enlargement of the prostate, and I rather suspected some abscess. The bladder was in very bad condition, and necessitated some other treatment than simple removal of the stone. I therefore made a median perineal incision and removed two calculi, one of which I found hanging almost like the clapper of a bell upon a fold of the bladder. This bladder was drained thoroughly, and the patient made a complete recovery. I believe that there is a field for this operation, simple removal of the stone by any operation, will not accomplish the object aimed at in every case, and I believe it could be better accomplished in many instances by drainage.

THE PRESIDENT.—It seems to me that the bladder is frequently the cause of the formation of the stone, and not the stone the cause of disease of the bladder. Of course, when the stone has formed the condition of the bladder is aggravated. It is better to establish drainage, and treat the bladder as if no stone were present. When this can be done by removing the stone through the perineum and establishing drainage afterward, it is better. I have done both, perineal lithotripsy and perineal litholapaxy, several times. In one case the patient had also a scrotal stone. An incision was made in the scrotum and the stone was removed, and then an opening was found in the urethra and through that a straight course into the bladder. In that instance the neck of the bladder was not at all dilated; litholapaxy was perfectly feasible. I have also done the operation where it was necessary to drain afterward, performing litholapaxy through the neck of the bladder without dilating it. If the neck of the bladder can not grasp the lithotrite water will not be retained, and it makes the crushing process difficult. Therefore, when the stone is reasonably small I think the neck of the bladder should not be dilated.

DR. HARRISON, in closing, said.—Dr. Chismore referred to the difficulty of making complete division of the prostate in cases where an enlarged prostate complicates stone by reason of the impossibility, when there is much enlargement, of getting the finger into the depression beyond. If you attempt to divide the prostate upon the ordinary curved staff you will find as a rule that you will only touch the circumference, and that circumference which is toward you, and therefore your drainage will only be imperfectly carried out. Some years ago in a case in which I wished particularly to divide the prostate in such a way as to cause free drainage in the sacculated portion above it, the patient unfortunately died. I found after death that I had really only made section of a portion which immediately faced me. Since that, where I have adopted perineal litholapaxy, or where I have wished to divide the prostate from a perineal opening, I acted in an entirely different way. I never attempt to make division of the prostate from without inward, as is done in ordinary operations for lithotomy. Having passed my finger into the prostatic urethra as far as I can conventionally do so, I then make my sections from within outward by passing a probe-pointed bistoury into the bladder, reversing the end just as you reverse the sound for the purpose of exploring the bladder, and then making section of the prostate directly toward me. That is the only way to make it perfectly certain that you have divided the prostate and made complete drainage.

DR. MUDD, of St. Louis, reported

AN UNUSUAL CASE OF URETHRAL CALCULUS.<sup>1</sup>

A stone weighing two hundred and eighty-one grains was found in front of the bulb, and seven or eight in the membranous portion.

DR. E. R. PALMER.—I might mention a similar case, in which, instead of one large urethral stone there were thirty-six smaller ones, twenty-four of them being above the bulbo-membranous junction. The operation was by perineal section, not cutting the prostate, dilating the neck of the bladder with the finger and washing it out. The man had had stricture thirteen years. When operated upon he had almost daily rigors and suffered from septic fever. I passed a filiform bougie with difficulty through the stricture, followed by Thompson's dilator, and then detected the calculi for the first time. After expanding the dilator and withdrawing it there came a calculus. After the completion of the operation the patient recovered from his septic fever and grew fat. I am a great believer in the distensibility of the urethra, including the prostatic urethra and neck of the bladder.

DR. CHISMORE, of San Francisco read a paper upon

THE EFFECTS OF RAPID CHANGES OF ALTITUDE IN AN ADVANCED CASE OF INTERSTITIAL NEPHRITIS.

In a journey from San Francisco to New York, the patient had suffered from the marked and sudden changes, and the author thought that diffuse nephritic cases, with heart complications, should avoid such travel.

DR. HYDE, of Chicago, read a paper on

SYPHILOMA OF THE VULVA.<sup>1</sup>

The next paper was by DR. WILLIAMS, of Norwich, Eng., upon cases of STONE IN THE BLADDER IN CONNECTION WITH SPLENIC LEUKÆMIA, attended with rapid accumulation of uric acid crystals.

The following gentlemen were elected officers of the Association for the ensuing year :

PRESIDENT—Dr. Robert W. Taylor, of New York.

VICE-PRESIDENT—Dr. John P. Bryson, of St. Louis.

SECRETARY AND TREASURER—Dr. Arthur T. Cabot, of Boston.

DR. KEYES then introduced the President-elect, Dr. R. W. Taylor, of New York, who said :

GENTLEMEN : I feel deeply the honor conferred upon me when you selected me as your Presiding officer for the next year, and with a deep sense of gratitude, and with a full appreciation of the responsibilities which the office carries, I shall try, with the valuable aid and advice of the council, and the coöperation of the members, to further establish the record which the Association has already made. If at the end of the year I shall have done as well as my predecessor has done, courteous to all, dignified in tone, perfectly fair, I shall certainly have reason to be satisfied. I thank you.

Adjourned.

<sup>1</sup> Will be published in a subsequent number of this Journal.

## Editorial.

### ANNOUNCEMENT OF THE NEW VOLUME.

**T**HE issue of the present number completes the sixth volume of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES. It is a source of great gratification to be able to record the remarkable success of this JOURNAL—a success altogether unprecedented in the history of special medical journalism. We believe that we can claim a subscription list several times larger than that of any publication devoted to this specialty.

The extraordinary favor which this JOURNAL has met with is due largely to the admirable work done in dermatology, syphilography and genito-urinary diseases in this country, the results of which we have presented to the profession, and also the endeavor on the part of the Editor to make the JOURNAL as practical as possible, adapting it to the wants of the general practitioner as well as the specialist. And it is proper to state, that in this effort the Editor has been afforded unlimited facility through the enterprise of the late publishers, Messrs. William Wood & Co., whose disposition to produce a superior work, has at no time been restricted by the expense involved. With the close of the present volume the publication of the JOURNAL will be transferred to the well-known publishing house of D. Appleton & Co. No essential change will be made either in the style or appearance of the JOURNAL. The chromolithographs and wood-cut illustrations which have formed so attractive and valuable a feature will be continued, and no expense spared to maintain their reputation for artistic excellence.

All arrears should be sent to William Wood & Co., and all renewals and subscriptions for the new volume, beginning with the January number, 1889, should be sent to D. Appleton & Co., 1, 3 and 5 Bond street, New York.

### TRANSACTIONS OF THE ASSOCIATION OF GENITO-URINARY SURGEONS.

Owing to the pressure upon our space consequent upon the publication of the official report of the proceedings of the Second Annual Meeting of this Association, a number of valuable papers and selections of dermatological interest have been carried over to the January issue. In the present number will be found an extended report of the discussions, with only a brief abstract of the papers, as many of them will be published in full.

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